



**UNIVERSAL
CURRICULUM**
Treatment of Substance Use Disorders

The Universal Treatment Curriculum for
Substance Use Disorders (UTC)

Participant Manual

UTC 7



Crisis Intervention for Addiction Professionals

4th Edition, 2020



DAP
Drug Advisory Programme



Crisis Intervention for Addiction Professionals

Participant Manual

4th Edition - 2020



Acknowledgments

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Disclaimer

The substance use disorder treatment interventions described or referred to herein do not necessarily reflect the official position of INL or the U.S. Department of State. The guidelines in this document should not be considered substitutes for individualized client care.

4th Edition

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PARTICIPANT ORIENTATION

Introduction

Welcome! This training will provide you with an understanding of the physiology of addiction as a brain disease and teach you about the effects and consequences of psychoactive substances.

Course 7: *Crisis Intervention for Addiction Professionals* is part of a training series developed through funding from the U.S. Department of State to The Colombo Plan Drug Advisory Programme (DAP). More information on the Colombo Plan can be found at <http://www.colombo-plan.org>.

The overall goal of the training series is to reduce the significant health, social, and economic problems associated with substance use disorders (SUDs) by building international treatment capacity through training, professionalizing, and expanding the global treatment workforce. The training prepares counselors for professional certification at the entry level by providing the latest information about SUDs and their treatment and facilitating hands-on activities to develop skills, confidence, and competence.

Congratulations for taking the time to learn more about your work!

The Training

The seven modules in this training series may be delivered over 2 consecutive days or may be offered over the course of several weeks or months. Your trainers have provided you with a specific agenda.

The learning approach for this training includes:

- Trainer-led presentations and discussions;
- Frequent use of creative learner-directed activities, such as small-group and partner-to-partner exercises and presentations;
- Reflective writing exercises;
- Periodic reviews to enhance learning retention; and
- Learning assessment exercises.

Your active participation is essential to making this a positive and productive learning experience!

Goals and Objectives for Course 7

Training goals

- To provide an overview of the nature of crisis and specific principles and steps for crisis intervention; and
- To provide participants with an opportunity to examine their personal self-care and safety awareness and practices.

Learning objectives

Participants who complete Course 7 will be able to:

- Define crisis and crisis intervention;
- Describe steps to managing a crisis;
- Demonstrate awareness of suicide intervention and prevention; and
- Demonstrate awareness of how to handle difficult or hostile clients while ensuring counselor and client safety.

Training materials

Training materials include:

- This *Participant Manual*;
- A notebook; and

Each module of your *Participant Manual* includes:

- Training goals and learning objectives for the module;
- A timeline;
- PowerPoint slides printed three to a page with space for you to write notes;
- Resource Pages containing additional information or exercise instructions and materials; and
- A module summary.

The *Participant Manual* also has a glossary (Appendix A) and a list of resources (Appendix B).

Your trainers will give you a notebook to use as your personal journal. You can use this journal in a number of ways. You can note:

- Topics you would like to read more about;
- A principle you would like to think more about;
- A technique you would like to try;
- Ways you might be able to add some of the things you're learning to your practice; and
- Possible barriers to using new knowledge.

Your trainers will also ask you to complete short writing assignments.

TAP 21 was developed in the United States to provide a common foundation on which to base training and certification of addiction professionals. The publication addresses these questions:

- What professional standards should guide counselors working with people with SUDs?
- What is an appropriate scope of practice for the field of SUD counseling?
- Which competencies are associated with positive treatment outcomes?
- What knowledge, skills, and attitudes should all SUD treatment professionals have in common?

TAP 21 can serve as a useful reference for you. Keep in mind, however, that it takes time and experience to develop counseling competence. TAP 21 represents an ideal set of goals, not a starting point. Don't get overwhelmed! You'll get there.

Getting the Most From Your Training Experience

To get the most from your training experience:

- If you have a supervisor, speak to him or her before the training begins. Find out what his or her expectations are for you.
- Think about what you want to learn from each module.
- Come to each session prepared; review the manual pages for the modules to be presented.
- Be an active participant. Participate in the exercises, ask questions, write in your journal, and think about what additional information you want.
- Speak to your supervisor (or co-workers, if you have no supervisor) after the training. Talk about what you learned to be sure you understand how the information relates to your job.
- Discuss with your supervisor or co-workers ways that you can put your learning into practice, and continue to follow up on your progress.
- **Have fun!**

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MODULE 0



Congratulations!

“

As a participant in this training, you are part of a rapidly growing global community of substance use professionals

”



U.S. DEPARTMENT of STATE

0.2

MODULE - 0

How is this global community of substance use professionals expanding?

In the last decade, a growing number of people are:

- ✓ being trained
- ✓ being credentialed
- ✓ studying at universities with specialized addiction programs
- ✓ operating in the context of a larger drug control system
- ✓ adhering to science and research-based approaches
- ✓ joining professional substance use associations
- ✓ networking through professional associations



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0.3

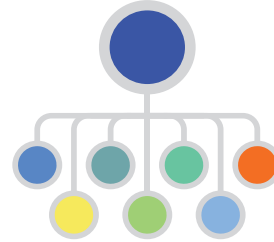
MODULE - 0

Who are the members of this global community of substance use professionals?



Individuals working worldwide in the substance use prevention and treatment fields in government, non-governmental organizations, civil society, and the private sector

Organizations that act as portals or “doorways” for individuals to join the global community



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0.4

MODULE - 0

ISSUP stands for the International Society of Substance Use Professionals

- ✓ ISSUP was launched by INL in 2015 as a global, not for profit, non-governmental organization to professionalize the global prevention and treatment workforce.
- ✓ ISSUP provides members with opportunities to share knowledge, exchange experiences, and stay abreast with current research in the field

Cont.



U.S. DEPARTMENT of STATE

0.5

MODULE - 0

ISSUP stands for the International Society of Substance Use Professionals

- ✓ There are more than 10,000 ISSUP members worldwide
- ✓ Join one of ISSUPs four levels of membership for free at: www.issup.net
- ✓ You can earn credit for this and other courses with ISSUP



U.S. DEPARTMENT of STATE

0.6

MODULE - 0



ICUDDR stands for the International Consortium of Universities for Drug Demand Reduction

- ✓ Global consortium of universities to promote academic programs that focus on science-based prevention and treatment
- ✓ Collaborative forum for individuals and organizations to support and share curricula, particularly this Universal Curriculum series, and experiences in the teaching and training of prevention and treatment knowledge

Cont.



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0.7

MODULE - 0

ICUDDR stands for the International Consortium of Universities for Drug Demand Reduction



Learn about specialized addiction programs at universities worldwide at www.icuddr.com



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0.8

MODULE - 0



THE COLOMBO PLAN



Global Centre for
Credentialing and Certification

GCCC stands for the Global Centre for Credentialing and Certification of Addiction Professionals

- ✓ The hours that you put into this training can be logged at GCCC and qualify you for exams and professional credentials
- ✓ GCCC credentials will help accelerate your career by indicating your passion and commitment to high standards

Cont.



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0.9

MODULE - 0

GCCC stands for the Global Centre for Credentialing and Certification of Addiction Professionals



Learn about how to apply the latest in research-based prevention and treatment at: www.globalccc.org



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0.10

MODULE - 0



Who funds and supports this global community of substance use professionals?

The U.S. Department of State's Bureau of International Narcotics and Law Enforcement Affairs (INL) which is funded by the U.S. taxpayer



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0.11

MODULE - 0

Where does this global community of substance use professionals meet?

- ✓ Digitally- through ISSUP and its networks and
- ✓ Face to face – through trainings, on university campus settings, and at conferences held at the global, national regional and local levels



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0.12

MODULE - 0

How does this global community of substance use professionals operate?

In the context of a larger international drug control environment that includes:

- United Nation's three international Drug Control Treaties or "Conventions"
- Commission on Narcotic Drugs (CND)
- International Narcotics Control Board (INCB)



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0.13

MODULE - 0

What are the key international organizations which operate in the context of this larger drug control environment?



The Colombo Plan Drug Advisory Program (DAP)



The Inter-American Drug Abuse Control Commission (CICAD) of the Organization of American States (OAS)



The African Union Commission (AUC)



The United Nations Office on Drugs and Crime (UNODC)



The World Health Organization (WHO)



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0.14

MODULE - 0



How can I participate in this global community of substance use professionals?

The easiest way is to become an active member of ISSUP!

- ✓ Register for free on the ISSUP website at www.issup.net
- ✓ Click on the “Apply for Membership” icon
- ✓ Select one of four levels of membership -all are free!
- ✓ Begin networking with others on an ongoing basis

It takes only a few minutes to register and you can immediately connect with over 10,000 ISSUP members worldwide!



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0.15

MODULE - 0

What are the benefits of being an active member of this global community of substance use professionals?

You can:

- ✓ Stay informed
- ✓ Implement best practices
- ✓ Access training and mentoring
- ✓ Turn training into credentials
- ✓ Access job postings
- ✓ Access up-to-date research
- ✓ Join a professional network
- ✓ Interact with other professional networks



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0.16

MODULE - 0

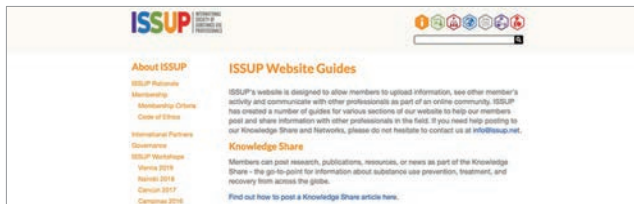
CALL TO ACTION

Next Steps

1. Join ISSUP at www.issup.net
2. Complete this training to earn credit
3. Send your credit hours to GCCC at www.globalccc.org

Participate in ISSUP

- Post on ISSUP: Find easy instructions for how to post on the ISSUP website
- Engage ISSUP's Networks: Connect with colleagues and broaden your impact



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0.17

MODULE - 0

MODULE 1

TRAINING INTRODUCTION

Content and timeline	21
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Summary	45

Content and Timeline	
Activity	Time
Ceremonial welcome	20 minutes
Trainer welcome, housekeeping, and ground rules	10 minutes
Partner exercise: Introductions	45 minutes
Presentation: Training materials	10 minutes
Presentation: Why this training?	15 minutes
<i>Break</i>	<i>15 minutes</i>
Large-group exercise: Training expectations	15 minutes
Presentation: What is a crisis?	20 minutes
Small-group exercise: Danger and opportunity in crisis	45 minutes

Module 1 Goals and Objectives

Training goals

- To create a positive learning community and environment;
- To give participants background information about why the training is being done;
- To give participants a summary of the overall training goals, objectives, and learning approach of the course; and
- To give participants information about what a crisis is.

Learning objectives

Participants who complete Module 1 will be able to:

- Explain the overall training goals and at least four objectives of the 2-day training;
- State at least one personal learning goal; and
- Describe the two elements of a crisis and the life cycle of a crisis.



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Treatment of Substance Use Disorders

The Universal Treatment Curriculum for Substance Use Disorders (UTC)

UTC 7

Crisis Intervention
for Addiction Professionals



MODULE 1—TRAINING INTRODUCTION



DAP
Drug Advisory Programme

Module 1 Learning Objectives

- Explain the overall UTC training goals and at least four objectives of the 2-day training
- State at least 1 personal learning goal
- Describe the 2 elements of a crisis and the life cycle of a crisis

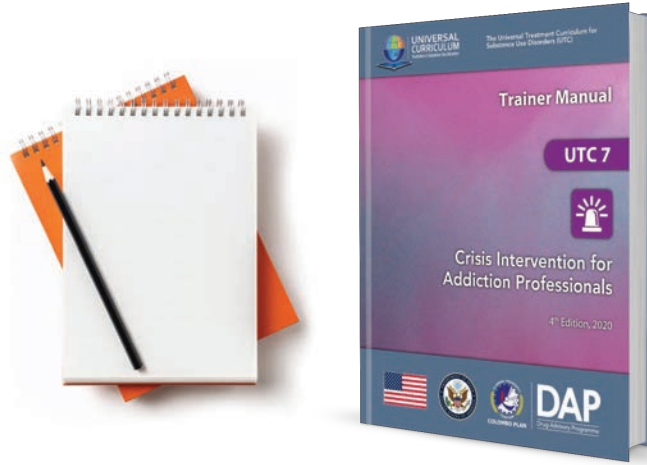
1.2

Exercise: Introductions

- What is your name?
- In what town do you live and work?
- What is your job title?
- What does your job entail?
- What aspect of crisis intervention is of interest to you?

1.3

Training Materials



1.4

The Global Problem

- 269 million people between the ages of 15 and 64 used illicit substances at least once in 2018



Source: UNODC. (2020). World drug report 2020. New York: United Nations.

1.5

The Global Problem

- 35.6 million people suffer from drug use disorders
- People who suffer from drug use disorder need treatment

Source: UNODC (2020). World Drug Report 2020. New York: United Nations

1.6

Diagnostic and Statistical Manual- 5 (DSM-5)

- Published by the American Psychiatric Association
- Provides standards criteria for the classification of mental disorders
- Substance Use Disorder (SUD) is defined as a problematic pattern of substance use leading to clinically significant impairment in daily life or distress
- Level of severity is measured on a continuum from mild to severe

Source: American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Washington, DC: Author

1.7

International Classification of Diseases (ICD-11)

- Published by WHO and covers health as a whole
- Covers more types of substances than ICD-10
- Disorders due to the use of substances are characterized by the pattern of use and consequences. ICD-11 identifies them as follows:
 - ▣ Single episode of harmful use of substances
 - ▣ Harmful pattern of use of substances
 - ▣ Substance dependence
 - ▣ Intoxication
 - ▣ Withdrawal

ICD-11 : *International Classification of Disease for Mortality and Morbidity Statistics*. (Eleventh Revision ed.): World Health Organisation.

1.8

The Global Problem

- An estimated 11.3 million people injected drugs in 2018
- About 12.6 percent (1.4 million) of those who inject drugs are HIV positive
- About 48.5 percent (5.5 million) of those who inject drugs are infected with Hepatitis C

United Nations Office on Drugs and Crime, World Drug Report 2020

1.9

The Global Problem

- Global consequences of SUDs are far-reaching and include:
 - ▣ Higher rates of hepatitis and tuberculosis
 - ▣ Lost productivity
 - ▣ Injuries and deaths from automobile and other accidents
 - ▣ Overdose deaths
 - ▣ Suicides
 - ▣ Violence

1.10

The Global Problem

- “There continues to be an enormous unmet need for drug use prevention, treatment, care and support, particularly in developing countries.”

Yuri Fedotov, Executive Director,
UNODC (2010-2019)

Source: UNODC. (2011). *World drug report 2011* (p. 9). New York: United Nations.

1.11

Training Series Goals

- Build international treatment capacity through:
 - ▣ Training
 - ▣ Professionalizing
 - ▣ Expanding the workforce

1.12

Courses in the Series

- UTC 1: *Introduction to the Science of Addiction* (3 days)
 - ▣ Foundational, not how-to or skills-based course
 - ▣ Overview of the physiology of addiction as a brain disease and the pharmacology of psychoactive substances

1.13

Courses in the Series

- UTC 2: *Treatment for Substance Use Disorders—The Continuum of Care for Addiction Professionals* (5 days)
 - ▣ Builds the foundation for understanding SUD treatment and the continuum of care
 - ▣ Provides an overview of recovery and recovery management, stages of change, components of SUD treatment and evidence-based practices

1.14

Courses in the Series

- UTC 3: *Common Co-Occurring Mental and Medical Disorders—An Overview for Addiction Professionals* (3 days)
 - ▣ Provides an overview of co-occurring disorders (COD), its relationship to one another
 - ▣ Discusses COD treatment and related issues as well as mental and medical disorders that commonly co-occur with SUD

1.15

Courses in the Series

■ UTC 4: *Basic Counseling Skills for Addiction Professionals* (5 days)

- Provides the basic understanding of the helping relationship
- Provides opportunities to enhance core counseling and motivational interviewing skills
- Introduces psychoeducation and recovery skills building as components of SUD treatment

1.16

Courses in the Series

■ UTC 5: *Intake, Screening, Assessment, Treatment Planning and Documentation for Addiction Professionals* (5 days)

- Provides an overview of effective, integrated screening, assessment and treatment planning in SUD treatment;
- Introduces the use of valid screening and assessment tools
- Highlights the importance of documentation in the process

1.17

Courses in the Series

■ UTC 6: *Case Management for Addiction Professionals* (2 days)

- ▣ Provides understanding of case management in SUD treatment
- ▣ Describes case management functions (planning, linkage, monitoring, advocacy, consultation, and collaboration)
- ▣ Provides opportunities to practice case management

1.18

Courses in the Series

- UTC 8: *Ethics for Addiction Professionals* (4 days)
 - ▣ Develops an understanding of ethics in SUD treatment practice
 - ▣ Provides an overview of the standards of professional conduct as defined in the Code of Ethics
 - ▣ Introduces the ethical decision-making model and provides opportunities for practice

1.19

UTC 7 Learning Objectives

- Define crisis
- Describe steps to managing a crisis
- Demonstrate awareness of suicide intervention and prevention
- Demonstrate awareness of how to handle difficult or hostile clients while ensuring counselor and client safety

1.20

Break

15 minutes

1.21

Large-Group Exercise: Training Expectations

- Write 2 training expectations on your index card

1.22

What is a Crisis?

- “Crisis is a perception or experiencing of an event or situation as an intolerable difficulty that exceeds the person’s current resources and coping mechanisms”

Source: James, R. (2008). *Crisis intervention strategies*, 6th ed. (p.3). Belmont, CA: Thomson.

1.23

What is a Crisis?

- A state of disorganization and confusion in which the client faces frustration and profound disruption in his or her life
- An immediate situation or short-term period when many emotions are felt—extreme uncertainty, fear, loss, grief
- An emotional state in response to disruption in the client's life not the disruption itself

1.24

What is NOT a Crisis?

- A problem that can be solved by an individual or a family is not a crisis, even if it is a big problem and very worrying

1.25

What Is a Crisis?

- Crisis - Danger
- Crisis - Opportunity
- Crisis is a **danger**—it threatens to overwhelm the client; for clients in recovery, it may result in relapse
- Crisis is an **opportunity** when a client may be more open to therapeutic intervention; it can plant seeds for positive change and personal growth

1.26

Small-Group Exercise: Danger and Opportunity in Crisis

- Choose a writer and a reporter
- Discuss how crisis can be a **danger** and list examples on the newsprint
- Discuss how crisis can be an **opportunity** and list examples on the newsprint

<u>Danger</u>	<u>Opportunity</u>

1.27

Resource Page 1.1: The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) Criteria for Substance Use Disorder¹

Substance Use Disorder (SUD) is a problematic pattern of use of an intoxicating substance leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

1. The substance is often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful effort to cut down or control use of the substance.
3. A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.
4. Craving, or a strong desire or urge to use the substance.
5. Recurrent use of the substance resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued use of the substance despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of its use.
7. Important social, occupational, or recreational activities are given up or reduced because of use of the substance.
8. Recurrent use of the substance in situations in which it is physically hazardous.
9. Use of the substance is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
10. Tolerance, as defined by either of the following:
 - a. A need for markedly increased amounts of the substance to achieve intoxication or desired effect.
 - b. A markedly diminished effect with continued use of the same amount of the substance.
11. Withdrawal, as manifested by either of the following:
 - a. The characteristic withdrawal syndrome for that substance (as specified in the DSM-5 for each substance).
 - b. The use of a substance (or a closely related substance) to relieve or avoid withdrawal symptoms

¹ <https://www.drugabuse.gov/publications/media-guide/science-drug-abuse-addiction-basics>

Resource Page 1.2 : ICD-11 Classification of Mental and Behaviour Disorder

Disorders due to substance use include single episodes of harmful substance use, substance use disorders (harmful substance use and substance dependence), and substance-induced disorders such as substance intoxication, substance withdrawal and substance-induced mental disorders, sexual dysfunctions and sleep-wake disorders.

Disorders due to use of substances

Disorders due to use of substance are characterised by the pattern and consequences of substance use. In addition to Substance intoxication, Substance has dependence-inducing properties, resulting in Substance dependence in some people and Substance withdrawal when use is reduced or discontinued. Substance is implicated in a wide range of harms affecting most organs and systems of the body, which may be classified as Single episode of harmful use and Harmful pattern of use. Harm to others resulting from behaviour during Substance intoxication is included in the definitions of Harmful use of substance. Several substance-induced mental disorders and substance-related forms of neurocognitive impairment are recognised.

Single episode of harmful use of substances

A single episode of use of substance that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. Harm to health of the individual occurs due to one or more of the following:

- (1) behaviour related to intoxication;
- (2) direct or secondary toxic effects on body organs and systems; or
- (3) a harmful route of administration.

Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behavior due to substance intoxication on the part of the person to whom the diagnosis of single episode of harmful use applies.

This diagnosis should not be made if the harm is attributed to a known pattern of substance use.

Exclusion

- Harmful pattern of use of substance
- Substance Dependence

Harmful pattern of use of substances

A pattern of psychoactive substance use that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. The

¹ ICD-11 : International Classification of Disease for Mortality and Morbidity Statistics. (Eleventh Revision ed.): World Health Organisation.

pattern of psychoactive substance use is evident over a period of at least 12 months if substance use is episodic or at least one month if use is continuous. Harm to health of the individual occurs due to one or more of the following:

- (1) behaviour related to intoxication;
- (2) direct or secondary toxic effects on body organs and systems; or
- (3) a harmful route of administration.

Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour related to psychoactive substance intoxication on the part of the person to whom the diagnosis of Harmful pattern of use of psychoactive substance applies.

Exclusion

- Substance Dependence
- Episode of Harmful Use of Substance

Substance Dependence

Dependence on a psychoactive substance is a disorder of regulation of psychoactive substance use arising from repeated or continuous use of psychoactive substance. The characteristic feature is:

- a strong internal drive to use the psychoactive substance, which is manifested by impaired ability to control use, increasing priority given to use over other activities and persistence of use despite harm or negative consequences. These experiences are often accompanied by a subjective sensation of urge or craving to use the psychoactive substance.
- physiological features of dependence may also be present, including tolerance to the effects of the psychoactive substance, withdrawal symptoms following cessation or reduction in use of the psychoactive substance, or repeated use of psychoactive substance or pharmacologically similar substances to prevent or alleviate withdrawal symptoms.

The features of dependence are usually evident over a period of at least 12 months but the diagnosis may be made if psychoactive substance use is continuous (daily or almost daily) for at least 1 month.

Exclusion

- Episode of Harmful Use of Substance
- Harmful pattern of use of substance

Intoxication

Intoxication is a clinically significant transient condition that develops during or shortly after the consumption of a psychoactive substance that is characterized by disturbances

in consciousness, cognition, perception, affect, behaviour, or coordination. These disturbances are caused by the known pharmacological effects of psychoactive substance and their intensity is closely related to the amount consumed. Presenting features may include impaired attention, inappropriate or aggressive behaviour, lability of mood, impaired judgment, poor coordination, unsteady gait, and slurred speech. At more severe levels of intoxication, stupor or coma may occur.

Withdrawal

Withdrawal is a clinically significant cluster of symptoms, behaviours and/or physiological features, varying in degree of severity and duration, that occurs upon cessation or reduction of use of alcohol in individuals who have developed dependence or have used psychoactive substances for a prolonged period or in large amounts. Presenting features of withdrawal may include autonomic hyperactivity, increased hand tremor, nausea, retching or vomiting, insomnia, anxiety, psychomotor agitation, transient visual, tactile or auditory hallucinations, and distractibility. Less commonly, the withdrawal state is complicated by seizures. The withdrawal state may progress to a very severe form of delirium characterized by confusion and disorientation, delusions, and prolonged visual, tactile or auditory hallucinations.

Note: The detailed diagnostic criteria can be accessed at the WHO website.

Note: At the time of the updating of this Course, the ICD-11 was in the final stages of revision and not yet formally released. However, INL and the Treatment Expert Advisory Group, in the interest of providing UC trainees with the latest and most current guidance on substance use disorders, requested inclusion of the ICD-11 language, 'as is.'

Resource Page 1.3: The Universal Treatment Curriculum for Substance Use Disorders (UTC) Basic Level Training Series

- UTC 1: *Introduction to the Science of Addiction*
- UTC 2: *Treatment for Substance Use Disorders—
The Continuum of Care for Addiction
Professionals*
- UTC 3: *Common Co-Occurring Mental and
Medical Disorders—An Overview for
Addiction Professionals*
- UTC 4: *Basic Counseling Skills for Addiction
Professionals*
- UTC 5: *Intake, Screening, Assessment, Treatment
Planning and Documentation for Addiction
Professionals*
- UTC 6: *Case Management for Addiction
Professionals*
- UTC 7: *Crisis Intervention for Addiction
Professionals (this course)*
- UTC 8: *Ethics for Addiction Professionals*

Module 1—Training Introduction, Summary

The global problem

- Psychoactive substance use continues to be a global problem. A survey done by the United Nations Office on Drugs and Crime (or UNODC) found that, in 2018, 269 million people between ages 15 and 64 used illicit substances at least once in 2018.¹ Illicit substances in the survey included opioids, cannabis, cocaine, other amphetamine-type stimulants, hallucinogens, and ecstasy, among others.
- These figures and other global statistics have a broad range. This is due to the difficulty of compiling such numbers. Different countries track and record statistical information in different ways, and global organizations such as UNODC and the World Health Organization (WHO) need to allow for these differences in their estimates.
- The UNODC report estimates a total of 35.6 million people between ages 15 and 64 suffer from drug use disorders. People who suffer from drug use disorders or people with drug use disorders are a subset of people who use drugs and are in need of treatment, health and social care, and rehabilitation.
- There are two classification systems used in the diagnosis of drug use disorders or SUDs, the Diagnostic Statistical Manual (DSM) and the International Classification of Diseases (ICD).
- Diagnostic Statistical Manual (DSM), published by the American Psychiatric Association, offers a common language and standards criteria for the classification of mental disorders.
- In 2013, the APA updated the DSM, replacing the categories of substance abuse and substance dependence with a single category: substance use disorder (SUD). SUD is defined as a problematic pattern of substance use leading to clinically significant impairment or distress as manifested by at least two of the 11 criteria occurring in a 12-month period. The level of severity is measured on a continuum from mild to severe.
- The symptoms associated with SUD fall into four major groupings: impaired control; social impairment; risky use; and, pharmacological criteria (i.e. tolerance and withdrawal).
- Another classification system is the International Classification of Diseases (ICD), published by the World Health Organization.
- It is distinguished from the DSM in that it covers health as a whole. Under ICD-11, patterns of psychoactive substance use are labelled:
 - Single episode of harmful use of a psychoactive substance - refers to a single episode of use of psychoactive substance that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others.
 - Harmful use - if the pattern is causing damage to health. The damage may be physical (as in the case of hepatitis from self-administration of injected drugs) or mental (i.g. episodes of depressive disorder secondary to heavy consumption of alcohol), and

1. UNODC. (2020). World drug report 2020 New York: United Nations.

- Dependence - if the use of a substance or a class of substances takes on a much more higher priority for a given individual than other behaviors that once had greater value. There is compulsion to use drugs and physical signs of a withdrawal state upon abstinence.
 - Intoxication – a clinically significant transient condition that develops during or shortly after the consumption characterised by disturbances in consciousness, cognition, perception , affect behaviour or coordination.
 - Withdrawal – is a clinically significant cluster of symptoms, behaviors and/or physiological features, varying in degree of severity and duration, that occurs upon cessation or reduction of use of alcohol in individuals who have developed dependence or have used psychoactive substances for a prolonged period or in large amounts. Presenting features of withdrawal may include autonomic hyperactivity, increased hand tremor, nausea, retching or vomiting, insomnia, anxiety, psycho-motor agitation, transient visual, tactile or auditory hallucinations, and distractibility.
- The UNODC report estimates a total of 35.6 million people between ages 15 and 64 suffer from drug use disorders. People who suffer from drug use disorders or people with drug use disorders are those subset of people who use drugs and are in need of treatment, health and social care, and rehabilitation.
 - The U.N Survey also found that:¹
 - 11.3 million people injected drugs in 2018
 - About 12.6 percent (1.4 million) of those who inject drugs are HIV positive.
 - About 48.5 percent (5.5 million) of those who inject drugs are infected with Hepatitis C.
 - Global consequences of SUDs are far-reaching and include, for example:
 - Higher rates of HIV/AIDS, hepatitis and tuberculosis;
 - Lost productivity;
 - Injuries and death due to automobile and other accidents;
 - Overdose hospitalizations and deaths;
 - Suicides; and
 - Violence.
 - The numbers are significant. Yuri Fedotov, Executive Director of UNODC (2010 to 2019), notes that “there continues to be an enormous unmet need for drug use prevention, treatment, care and support, particularly in developing countries.”² There are a number of reasons for this, but one reason is a lack of adequate treatment capacity.

The training series

- This course is part of a training series developed through funding from the U.S. Department of State to The Colombo Plan.

1. United Nations Office on Drugs and Crime, World Drug Report 2020

2. UNODC. (2011). World drug report 2011 (p.9). New York: United Nations.

- The overall goal of the training series is to reduce the health, social, and economic problems associated with SUDs by building international treatment capacity through training, professionalizing, and expanding the global treatment workforce.
- The series prepares counselors for professional certification at the entry level by providing them with necessary information and with specific skills training. See You will find a list of the courses included in the training series on Resource Page 1.3 in your manuals.

Other Courses in the series

- Course 1: Introduction to the Science of Addiction is a 3-day course that presents a comprehensive overview of addiction, provides an understanding of the physiology of addiction as a brain disease, and describes the pharmacology of psychoactive substances.
- Course 2: Treatment for Substance Use Disorders—The Continuum of Care for Addiction Professionals is a 5-day foundational course. By this we mean that it provides a necessary foundation for learning about SUD treatment. It is not a how-to or skills-based course, but it provides a context for the skills-based courses later in the series. Course 2 provides an overview of recovery, recovery management, stages of change, principles of effective treatment, components of treatment, factors affecting treatment outcomes, and evidence-based practices, including couples and family counseling.
- Course 3: Common Co-Occurring Mental and Medical Disorders—An Overview for Addiction Professionals is a 3-day course. It is also a foundational course and provides an overview of the relationship of co-occurring disorders to one another and to SUD-related treatment issues. It outlines brief descriptions of the most commonly co-occurring mental and medical disorders with SUD.
- Course 4: Basic Counseling Skills for Addiction Professionals is a 5-day skills-based course. It provides an overview of the helping relationship. It also provides opportunities to learn and practice core counseling and basic motivational interviewing skills which are essential at every stage of treatment and in every type of counseling situation, including working with families. Basic group (for clients and family members) counseling and psychoeducational group skills also are covered in the course.
- Course 5: Intake, Screening, Assessment, Treatment Planning and Documentation for Addiction Professionals is a 5-day skills-based course that teaches effective, integrated assessment and treatment/service planning. It also addresses the importance of documentation in the treatment process.
- Course 6: Case Management for Addiction Professionals is a 2-day foundational and skills-based course that provides an overview of case management in SUD treatment and provides skills practice in case management functions such as planning, linkage, monitoring, advocacy, consultation, and collaboration.
- Course 7: Crisis Intervention for Addiction Professionals, a 2-day course, addresses the concept of crisis as a part of life and provides guidelines for and practice in crisis management, including managing suicide risk. It also addresses ways counselors can avoid personal crisis situations by providing information and exercises about counselor self-care.

- UTC 8: Ethics for Addiction Professionals is a 4-day course that aims to develop an understanding of ethics in SUD treatment and provides an overview of professional conduct as defined in the Code of Ethics. It provides the opportunity to learn and practice the process of ethical decision making. The course also addresses the importance of supervision as part of ethical practice.

What is a crisis?

- There are many definitions of crisis. One formal definition of personal crisis that is useful is: “crisis is a perception or experience of an event or situation as an intolerable difficulty that exceeds the person’s current resources and coping mechanisms.”¹
- When working with clients in crisis, it is important to note that the life cycle of a crisis is short. The resolution can be positive or negative, but the crisis will end.
- Our role as counselors is to work toward a positive resolution with our clients. This means helping clients find more resources and develop coping mechanisms to overcome the intolerable difficulty.
- Crisis can also be viewed as:
 - A state of disorganization and confusion in which the client faces frustration and profound disruption in his or her life;
 - An immediate situation or short-term period when many emotions are felt—extreme uncertainty, fear, loss, grief; or
 - An emotional state in response to disruption in the client’s life, not the disruption itself.
- It may be helpful to state what is not a crisis. A problem that can be solved by an individual or a family is not a crisis, even if it is a big problem and very worrying.
- Also, it is common for different people to have varying reactions to events, so what might cause a crisis for one person might be manageable for another.
- Many incorrectly believe that the Chinese characters for crisis use the symbol for danger and the symbol for opportunity. Although this is a misinterpretation of the Chinese characters, the idea of combining danger and opportunity is a helpful way of looking at crisis and crisis management.
 - Crisis is a danger; it threatens to overwhelm the client. For clients in recovery, it may result in relapse.
 - Crisis is an opportunity when a client may be more open to therapeutic intervention. It can be a time to plant seeds for positive change and personal growth.
- Our role as counselors for clients in crisis is to help mitigate, or lessen, the danger, especially to oneself or others, and help clients see opportunities, even if only eventually.

1. Source: James, R. (2008). Crisis intervention strategies, 6th ed. (p.3). Belmont, CA: Thomson

MODULE 2

WHAT CAUSES A CRISIS?

Content and timeline	51
Training goals and learning objectives	51
PowerPoint slides	52
Summary	59

Content and Timeline	
Activity	Time
Introduction to Module 2	5 minutes
Presentation: Causes of a crisis	20 minutes
<i>Lunch</i>	<i>60 minutes</i>
Small-group exercise: Three categories of causes	60 minutes

Module 2 Goals and Objectives

Training goals

- To provide information about a variety of causes of crisis; and
- To highlight the cumulative effect of causes.

Learning objectives

Participants who complete Module 2 will be able to:

- Identify at least six situations that can cause a crisis for clients;
- Categorize causes into three types; and
- Describe the cumulative effects of multiple causes.



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MODULE 2—WHAT CAUSES A CRISIS



Module 2 Learning Objectives

- Identify at least 6 situations that can cause a crisis for clients
- Categorize causes into 3 types
- Describe the cumulative effects of multiple causes

2.2

Possible Causes of a Crisis

- Lack of access to essential services and supports
- Mental and substance use disorders can cause or contribute to crisis
- Co-occurring medical or mental disorders
- Disease Pandemic
- Poverty
- Unstable Housing
- Stigma and Discrimination
- Victimization
- Family Issues
- Bereavement

2.3

Lunch

60 minutes

2.4

Small-Group Exercise: 3 Categories of Causes

- Form 3 small groups; each group has an assigned category
- Identify a note-taker and a presenter
- Create a list of possible causes that fit your assigned category
- Provide an example if you think it is needed

2.5

What Causes a Crisis?

External Factors

- Bereavement
- Sudden/severe illness in the family
- Job loss/unemployment
- Natural disaster
- Surgery (unplanned)
- Imprisonment
- Terrorism
- Trauma
- Displacement from home due to conflict, civil unrest, or war
- Pandemic
- Other type of sudden and severe loss

2.6

What Causes a Crisis?

Internal Distress

- Hopelessness
- Despair
- Depression
- Suicidal impulses
- Psychotic or manic episode
- Post-traumatic stress
- Unpleasant substance use reaction

2.7

Internal Distress and External Causes

- Internal distress can lead to external causes of crisis and vice versa

2.8

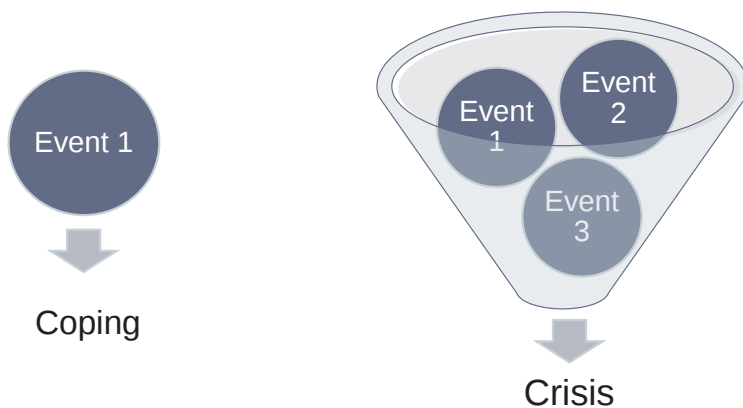
What Causes a Crisis? Transitional States

- Relocation
- Marriage
- New family member or baby
- Job change
- Retirement
- Separation
- Divorce

2.9

Cumulative Effects

- The *cumulative* effect of multiple events or internal states can lead to crisis



2.10

Module 2—What Causes a Crisis?, Summary

Causes of a crisis

- Crisis is not an inevitable consequence of substance use or mental health problems, but it can be caused by the combined impact of a host of factors, including:
 - Lack of access to essential services and supports
 - Mental and substance use disorders can cause or contribute to crisis
 - Co-occurring medical or mental disorders
 - Disease Pandemic – Covid 19 Pandemic
 - Poverty
 - Unstable Housing
 - Stigma and Discrimination
 - Victimization
 - Family Issues such as divorce, separation, suicide in the family, and broken relationships with children.
 - Bereavement
- Lack of access to essential services such as Methadone and counseling services and necessary support in some situations can create a crisis. Also, the high cost of medication may mean that people will go without it—or go without food or heat. Either factor can contribute to a crisis spiraling out of control.
- Mental and substance use disorders can also cause or contribute to crisis, especially when one or more of the other problems mentioned previously are present. SUDs can worsen other physical and behavioral health issues.
- Co-occurring medical disorders can contribute to crisis in many ways:
 - The condition or illness can cause depression and fatigue.
 - Inability to access care or medication can mean little hope of improvement.
 - A serious illness or condition can lead to unemployment and poverty.
- Disease Pandemic –COVID-19 pandemic when essential services, supports and treatment services became unavailable which could lead to a crisis. In that situation, people will experience difficulty in shopping for groceries, sanitizers or inability to access family and friends.
- Poverty can create or contribute to a crisis if clients cannot provide food, shelter, and clothing for themselves and their families.
- Similarly, someone who is homeless, or one rent payment away from homelessness, is vulnerable to crisis.

- We've talked about stigma and discrimination in other trainings. Stigma, discrimination, or bullying can also create or contribute to a crisis.
- Similarly, victimization causes trauma and can contribute to or cause a crisis for a client.

Family Issues

- Bereavement such as loss of significant ones— is the life-event that everybody experiences during their lives, but it is sometimes associated with intense suffering that can increase the risk of developing mental and physical health problems. If that happens to substance users, drug consumption can be triggered.^{1,2,3}

Categories of causes

- There are three basic categories of possible causes of crisis:
 - External factors;
 - Internal distress; or
 - Transitional states.
 - Each is a category of possible causes of crisis:
- External factors are those things that may happen to a client: losing a job, experiencing trauma, and so on.
- Internal distress means something that is taking place within the client: physical pain, a psychotic state, and so on.
- Transitional states are those times in a client's life when much change is taking place: moving, getting married, and so on.
- External factors may include:

Bereavement (loss of a loved one);	Trauma;
Sudden and severe illness in the family;	Displacement from home because of conflict, civil unrest, or war;
Job loss and unemployment;	Divorce or separation;
Natural disaster;	Broken relationships with children;
Surgery	Suicide in the family;
Imprisonment;	Pandemic; and,
Terrorism;	Other type of sudden and severe loss.

1. Stroebe, M., Schut, H., & Stroebe, W. (2007). Health outcomes of bereavement. *Lancet*, 370(9603), 1960-1973. doi:10.1016/s0140-6736(07)61816-9
2. Denny, G. M., & Lee, L. J. (1984). Grief work with substance abusers [Press release]
3. Zuckoff, A., Shear, K., Frank, E., Daley, D. C., Seligman, K., & Silowash, R. (2006). Treating complicated grief and substance use disorders: a pilot study. *J Subst Abuse Treat*, 30(3), 205-211. doi:10.1016/j.jsat.2005.12.001

- Internal distress means something that is taking place within the client: physical pain, a psychotic state, and so on. Internal factors may include:
 - Hopelessness;
 - Despair;
 - Depression;
 - Suicidal impulses;
 - Psychotic or manic episode;
 - Post-traumatic stress; and
 - An unpleasant substance use reaction
- It's important to note that internal distress also can lead to an external cause of crisis. For example, a person's behavior in a manic state may lead to an arrest, a job loss, or other unpleasant consequences. Or a person with post-traumatic stress disorder may overreact to a situation and create external problems.
- Transitional states are those times in a client's life when much change is taking place: moving, getting married, and so on. Transitional states may include:
 - Relocation;
 - Marriage;
 - New family member or baby;
 - Job change;
 - Retirement
 - Separation; and
 - Divorce.
- Displacement or forced migration, immigration, pandemics, epidemics, losses (not only of people, but also pets, heritage with emotional value) and violence in all its manifestations
- One other big factor that can cause a crisis: The cumulative effects of multiple things that happen or exist—and those could be from any or all of the categories. A person may be able to cope well with one event—or even two—but make that three, four, or more events and the person can no longer cope, leading to a crisis situation.

MODULE 3

20 GUIDELINES FOR CRISIS MANAGEMENT

Content and timeline	65
Training goals and learning objectives	65
PowerPoint slides	66
Resource pages	83
Summary	85

Content and Timeline	
Activity	Time
Introduction to Module 3	5 minutes
Presentation: 20 guidelines for crisis management	15 minutes
Small-group exercise: Triad role-plays	35 minutes
<i>Break</i>	<i>15 minutes</i>

Module 3 Goals and Objectives

Training goals

- To provide an overview of guidelines for crisis management; and
- To provide an opportunity for participants to practice using the 20 guidelines for crisis management.

Learning objectives

Participants who complete Module 3 will be able to:

- Describe crisis management;
- Understand the crisis management guidelines; and
- Use the crisis management guidelines in practice role-plays.



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MODULE 3—20 GUIDELINES FOR CRISIS MANAGEMENT



DAP
Drug Advisory Programme

Module 3 Learning Objectives

- Describe crisis management
- Understand the 20 crisis management guidelines
- Use the crisis management guidelines in practice role-plays

3.2

What Is Crisis Management?

- Offers those in crisis immediate help to solve the problems they are facing
- Reestablishes balance or stability in a client's life
- Is immediate, short term, and time limited

3.3

1. Assess Available Support

- Identify and assess available help from family, friends, or other supports (12-Step group, sponsor, clergy)
- Involve family if necessary and possible
- Provide or make referrals for family therapy or other community services

Crisis Intervention and Management for Addiction Professionals. (2010)

3.4

2. Assess Risk

- Assess whether the client or others are at risk
- Have program procedures in place for clients who indicate they plan to harm themselves or others
- Refer to appropriate mental health resources or a hospital

Crisis Intervention and Management for Addiction Professionals. (2010)

3.5

3. Meet Face-to-Face

- Arrange a face-to-face interview with the client immediately
- Take precautions for the safety of both client and counselor

Crisis Intervention and Management for Addiction Professionals. (2010)

3.6

4. Plan

- Help the client make a clear plan for getting through the crisis
- Set time related goals, such as a plan for the next minute, hour, or even the next day.
- Involve significant others for support

Crisis Intervention and Management for Addiction Professionals. (2010)

3.7

5. Set Short-Term Goals

- Help the client set clear and achievable short-term goals
- Enlist significant others to provide support

Crisis Intervention and Management for Addiction Professionals. (2010)

3.8

6. Normalize Feelings

- Normalize (reduce the intensity of the feeling) the client's reactions to the situation without minimizing clients' problems and their perception.
- Actively listen without passing judgment.
- Example statements could be
 - "It must have been a very rough day for you to do that"
 - "It must have been a very tough decision to harm yourself "
 - " It's ok to feel....."
 - "It's understandable that you're....."

Crisis Intervention and Management for Addiction Professionals. (2010)
The Supporter's Toolbox Tips: Normalize their feelings. (2020). Retrieved from <https://eoc.unc.edu/normalizefeelings/>
Carpetto, G. (2008). Interviewing and Brief Therapy Strategies: An Integrative Approach.

3.9

7. Understand Context

- Understand what the situation means to the client
- Elicit information about personal, cultural, and social factors that may affect how the client views the situation

Crisis Intervention and Management for Addiction Professionals. (2010)

3.10

8. Explore Coping Strategies

- Help the client explore effective coping strategies that were used in the past
- Help the client identify past ineffective coping strategies, including substance use, and why these did not work
- Goal: Move the client from feeling like a victim to feeling empowered

Crisis Intervention and Management for Addiction Professionals. (2010)

3.11

9. Focus on the Here and Now

- Do *not* attempt to solve long-term problems
- Focus only on the present

Crisis Intervention and Management for Addiction Professionals. (2010)

3.12

10. Address Physical Symptoms

- Address any physical anxiety and panic symptoms
- Speak slowly and calmly
- Encourage the client to breathe slowly and deeply

Crisis Intervention and Management for Addiction Professionals. (2010)

3.13

11. Protect Yourself

- Protect yourself and do not take risks:
 - ▣ Do not get between suicidal clients and a window or a ledge
 - ▣ Call in backup if you are dealing with an agitated or angry client

Crisis Intervention and Management for Addiction Professionals. (2010)

3.14

12. Follow Program Guidelines

■ Do not break rules:

- ▣ Do not physically restrain a client unless you have been specifically trained to do so and there is program policy allowing it;
- ▣ Do not drive a client anywhere unless, there is program policy allowing it.

Crisis Intervention and Management for Addiction Professionals. (2010)

3.15

13. Use a Team Approach

- Never act alone when helping a client in crisis
- Call on your supervisor or a colleague

Crisis Intervention and Management for Addiction Professionals. (2010)

3.16

14. Stay Calm

- Remain calm, collected, and in charge when interacting with the client
- Be straightforward and direct
- Do not give false assurances

Crisis Intervention and Management for Addiction Professionals. (2010)

3.17

15. Do Not Confront

- Do not assign blame
- Reinforce that you are on the client's side in a crisis and that you care about the client's well-being

Crisis Intervention and Management for Addiction Professionals. (2010)

3.18

16. Be Alert for Relapse

- Remember:
 - ▣ Clients with SUDs are more likely to use during a crisis
 - ▣ Substance use can worsen a co-occurring mental disorder
- Remind clients of the risk of a return to substance use
- Include relapse prevention strategies in planning

Crisis Intervention and Management for Addiction Professionals. (2010)

3.19

17. Be Prepared

- Be sure you know about and are prepared to mobilize appropriate resources:
 - ▣ Law enforcement
 - ▣ Mobile crisis services
 - ▣ Medical assistance
 - ▣ Crisis treatment of mental disorders

Crisis Intervention and Management for Addiction Professionals. (2010)

3.20

18. Follow-Up

- Develop a follow-up plan for the client once the crisis is resolved
- Follow-up on the client's progress

Crisis Intervention and Management for Addiction Professionals. (2010)

3.21

19. Take Care of Yourself

- Manage your own level of stress
- Use self-care strategies
- Maintain professional boundaries

Crisis Intervention and Management for Addiction Professionals. (2010)

3.22

20. Let Others Take the Lead

- If you do not feel comfortable handling a crisis, let others take the lead
- Crisis management is not for everyone
- Forcing yourself to take the lead when you are not comfortable could have disastrous results

Crisis Intervention and Management for Addiction Professionals. (2010)

3.23

Triad Role-Play Exercise

- Review the guidelines—Resource Page 3.1
- Determine who will be the counselor, the client, and the observer(s)
- The client will simulate a crisis situation
- The counselor will use the 20 guidelines to role-play a crisis intervention session
- The observer will note guidelines followed and provide feedback

3.24

Break

15 minutes

3.25

Resource Page 3.1: 20 Guidelines for Crisis Management¹

1. Identify and assess the client's access to help from family, friends, or other supports (such as a 12-Step program or support group). Make sure the client has access to at least one support, whether a spouse, another family member, friend, clergy person, or sponsor from a 12-Step program.

If the client has close family relationships, the family may need to become involved in the client's treatment. The crisis will have an impact not only on the client, but also on his or her family members. If your program does not provide family therapy, make appropriate referrals for this and other community services in your area.

2. Assess whether the client and others are at risk. Your program should have procedures in place to handle a situation in which clients indicate they might put their or others' safety at risk. Immediately contact appropriate mental health resources or a hospital when a client indicates the possibility of harm to himself or herself or another.
3. If possible, arrange a face-to-face interview with the client in a safe place (for both the client and the counselor) as soon as possible. When meeting with the client, make sure you both can easily exit the area. Do not block the exit with a desk, chair, or other furniture.
4. Whether dealing with a client in person or over the phone, help the client make a clear plan for getting through the crisis. The plan should include time-related goals or target dates.
5. Help the client set clear and achievable short-term goals. If possible, involve significant others to offer support.
6. Normalize the client's reactions to the situation without minimizing them. Explore the client's feelings and emotions, and actively listen without passing judgment.
7. Understand what the situation means to the person. Elicit information about personal, cultural, and social factors that may affect how the client views the situation.
8. Help the client identify and regain effective coping strategies and resources that he or she used in the past to help during this crisis. You can also help the client identify past unsuccessful coping strategies, including substance use, and why these did not work. Move the client from feeling like a victim to feeling empowered. Do this by directing the client and engaging in problem-solving.
9. Do not attempt to solve long-term problems during this time. Focus on the present.
10. Address any physical panic symptoms. Speak slowly and calmly, and encourage the client to breathe slowly and deeply to avoid hyperventilation.

¹From NAADAC - The Association for Addiction Professionals.

11. Protect yourself and do not take risks when interacting with the client. Do not get between suicidal clients and a window or a ledge, because such clients could take you with them if they decide to take action. Call in backup if you are dealing with an agitated or angry client.
12. Follow your program's guidelines and policies. For example:
 - Do not restrain a client unless you have been specifically trained to do so and it is permissible by program policy; and
 - Do not drive a client anywhere unless you or others are allowed to do so, as indicated by your program's policy.
13. Use a team approach, and do not act alone.
14. Remain calm, collected, and in charge. Be straightforward and direct with the client, but do not give false assurances that everything will be fine. It is very helpful to get extra training in crisis de-escalation.
15. Keep confrontation to a minimum, and do not assign blame or take sides. Make sure clients know that you care about their well-being.
16. Keep in mind that clients with psychoactive SUDs are more likely to use alcohol or drugs during a crisis; doing so can lower impulse control, cognitive ability, and judgment. Alcohol and drug use can also exacerbate a co-occurring mental disorder.
17. Be prepared to make appropriate referrals to law enforcement, mobile crisis teams, medical professionals, and others. If you or another professional decides that hospitalization is required, make sure that this support can be provided immediately.
18. Develop a followup plan, as needed, once the crisis is resolved. If you refer the client to another program to handle the crisis, you still may want the client to return to your program for followup and can make arrangements with the referred program (with the client's consent).
19. Manage your own level of stress when dealing with a client in crisis. Maintain professional boundaries and make appropriate referrals. Use self-care strategies to maintain your own well-being. Programs should have procedures in place for counselors to debrief with the treatment team and their supervisors.
20. If you do not feel comfortable handling a crisis, let others take the lead. Not everyone is suited for crisis management. Forcing yourself to take the lead when you are not comfortable could have disastrous results.

Module 3—20 Guidelines for Crisis Management, Summary

Introduction

- Crisis management is the process by which a counselor provides a person in crisis with immediate help to solve the problem he or she is facing and to reestablish balance or stability in his or her life.
- Crisis management is immediate, short term, and time limited.
- Counselors and other helping professionals who are dealing with a client who is experiencing a crisis need to follow a procedure to ensure effective client treatment and the safety of both the client and the counselor.
- The 20 guidelines that follow are from NAADAC, The Association for Addiction Professionals, in the United States.
- The details of 20 guidelines for crisis management is available in Resource page 3.1.

Crisis and intentionality

- We talked about intentionality in counseling in Course 4. By intentionality we mean that a counselor goes into an individual or group counseling session with a clear objective in mind and does not allow a session to take on its own momentum.
- Although it is important that a counselor be flexible to change direction when it is truly warranted (for example, a serious suicide threat or death of a loved one), it is also important that a counselor not allow SUD treatment to repeatedly go off track in response to crisis after crisis.

MODULE 4

MANAGING SUICIDE RISK

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Summary	123

Content and Timeline	
Activity	Time
Introduction to Module 4	5 minutes
Presentation: Introduction to suicide, suicidal thoughts, and suicidal behaviors	15 minutes
Reflective exercise: Suicide and culture	15 minutes
Small-group exercise: Suicide warning signs	20 minutes
Small-group presentations: Four-step process for intervention, Part I: Preparation	30 minutes
Day 1 wrap-up	5 minutes
End of day 1	
Welcome and Day 1 review	5 minutes
Small-group presentations: Four-step process for intervention, Part II: Presentations	25 minutes
Presentation: Documenting intervention	10 minutes
Small-group exercise: Case studies	40 minutes
<i>Break</i>	<i>15 minutes</i>

Module 4 Goals and Objectives

Training goals

- To provide basic information about suicidal thoughts and behaviors and their relationship to substance use disorders;
- To teach participants suicide risk factors and warning signs;
- To provide information on a four-step model of intervention; and
- To provide an opportunity to practice the four-step model of intervention.

Learning objectives

Participants who complete Module 4 will be able to:

- Describe the relationship between substance use and suicidal thoughts and behaviors;
- Identify risk factors and warning signs of suicide;
- Describe a four-step process for intervening; and
- Demonstrate applying this process in a case-study exercise.



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MODULE 4—MANAGING SUICIDE RISK



DAP
Drug Advisory Programme

Module 4 Learning Objectives

- Describe the relationship between substance use and suicidal thoughts and behaviors
- Identify risk factors and warning signs of suicide
- Describe a 4-step process for intervening
- Demonstrate applying this process in a case-study exercise

4.2

Suicide

- Every year, over 800,000 people die from suicide:
 - ▣ A global mortality rate of 11.4 per 100,000 people
 - ▣ 1 death every 40 seconds

Suicide: facts and figures



Graphic source: <https://www.dailyinfographic.com/suicide-facts-and-figures>

Source: World Health Organization. (2014). *Suicide prevention (SUPRE): The problem*. Retrieved from http://www.who.int/mental_health/prevention/suicide/suicideprevent/en/

4.3

Suicide Risk and SUD

- Suicide is a leading cause of death among people who misuse alcohol and drugs.
- Substance misuse significantly increases the risk of suicide:
 - ▣ Approximately 22 percent of deaths by suicide involved alcohol intoxication, with a blood-alcohol content at or above the legal limit
 - ▣ Opiates (including heroin and prescription painkillers) were present in 20 percent of suicide deaths, marijuana in 10.2 percent, cocaine in 4.6 percent, and amphetamines in 3.4 percent.

4.4

Suicide Risk and SUDs

- Compared with the general population (in the United States):
 - ▣ Individuals in treatment for alcohol abuse or dependence are at about 10 times greater risk of suicide
 - ▣ Individuals who inject drugs are at about 14 times greater risk of suicide
- Among those populations known to be at increased risk of suicide are people who use drugs (PWUD)^{11–13}. Evidence from epidemiological and clinical research indicates a 7- to 22-fold increase in suicide mortality among PWUD relative to that expected in the general population

Sources: Wilcox, H. C., Conner, K. R., & Caine, E. D. (2004). Association of alcohol and drug use disorders and completed suicide: An empirical review of cohort studies. *Drug and Alcohol Dependence*, 76, S11–S19

Murphy L, Lyons S, O'Sullivan M and Lynn E. Risk factors for completed suicide among people who use drugs: A scoping review protocol [version 1; peer review: awaiting peer review] *HRB Open Research* 2020, 3:45 <https://doi.org/10.12688/hrbopenres.13098.1>

4.5

Suicide Risk Factors

- Prior history of suicide attempts (most potent risk factor, BUT about half of all deaths by suicide are first-time attempts)
- Family history of suicide
- Severe substance use

4.6

Suicide Risk Factors (continued)

- Co-occurring mental disorder:
 - ▣ Depression (including substance-induced)
 - ▣ Trauma and Stressor-related disorder (PTSD)
 - ▣ Severe mental illness (schizophrenia, bipolar disorder)
 - ▣ Personality disorder (borderline and antisocial personality disorders)
 - ▣ Anorexia nervosa

4.7

Suicide Risk Factors (continued)

- History of childhood abuse (especially sexual)
- Stressful life circumstances:
 - ▣ Low level of education, job loss, continuing unemployment
 - ▣ Divorce or separation
 - ▣ Legal difficulties
 - ▣ Major and sudden financial losses
 - ▣ Social isolation, low social support
 - ▣ Conflicted relationships

4.8

Suicide Risk Factors (continued)

- Proneness to negative affect (sadness, anxiety, anger)
- Aggression, impulsiveness
- Gun ownership or access to a gun or another method

4.9

Suicidal Ideations and Suicide Plans

- Suicidal ideations range from:
 - ▣ Fleeting to persistent thoughts
 - ▣ Vague to highly specific thoughts
- Suicide plans signal a more serious risk and range from:
 - ▣ Vague and unrealistic
 - ▣ Specific and feasible

4.10

Suicide Behaviors

- Suicide: Acute, deliberate act of self-harm resulting in death with at least some intention to die
- Suicide attempt:
 - ▣ Intention (How intensely did the person want to die? To what extent did he or she expect to die?)
 - ▣ Lethality (How likely was it that the behavior would have led to death?)

4.11

Suicide Direct Warning Signs

- Suicidal communications:
 - ▣ Oral threats to hurt or kill oneself
 - ▣ Talk of wanting to die
- Seeking access to a method:
 - ▣ Guns, pills, and others
- Making preparations:
 - ▣ Giving away possessions
 - ▣ Saying goodbye



4.12

Suicide Indirect Warning Signs

Mnemonic (IS PATH WARM)

- I = Ideation
- S = Substance Abuse
- P = Purposelessness
- A = Anxiety
- T = Trapped
- H = Hopelessness

4.13

Suicide Indirect Warning Signs (continued)

- W = Withdrawal
- A = Anger
- R = Recklessness
- M = Mood Changes

4.14

Reflective Exercise: Suicide and Culture

- How does your culture view suicide?
- Are there warning signs that differ from those we've discussed?
- What is your personal view of suicide?



4.15

Small-Group Exercise: Warning Signs

- Turn to Resource Page 4.1
- Select a note-taker and presenter for your group
- For **each** case study, answer these questions:
 - ▣ Is there a direct warning sign (or more than one) in the description?
 - ▣ Is there an indirect warning sign or risk factor (or more than one) in the description?
 - ▣ Do you think this person is at low, moderate, or high risk of committing suicide? Why?

4.16

4-Step Process for Intervention

- Gather information
- Access supervision
- Take responsible action
- Extend the action

4.17

Small-Group Presentations: 4-Step Process for Intervention

- Read your assigned Resource Page:
 - ▣ Resource Page 4.2: Step 1-Gather Information
 - ▣ Resource Page 4.3: Step 2-Access Supervision
 - ▣ Resource Page 4.4: Step 3-Take Responsible Action
 - ▣ Resource Page 4.5: Step 4-Extend the Action
- Include all information in your presentation
- Use newsprint, markers, colored paper
- Include a brief role-play scenario to illustrate your step

4.18

Day 1 Wrap-up



4.19



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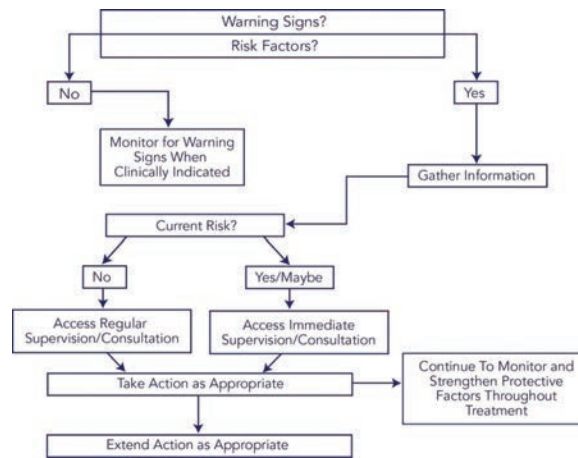


MODULE 4—MANAGING SUICIDE RISK



DAP
Drug Advisory Programme

4-Step Process: Decision Tree



Source: Center for Substance Abuse Treatment. (2009). *Addressing suicidal thoughts and behaviors in substance abuse treatment*. Treatment Improvement Protocol (TIP) Series 50. HHS Publication No. (SMA) 09-4381. Rockville, MD: Substance Abuse and Mental Health Services Administration.

4.21

Document GATE

- Gather Information - Assessment of suicide risk
- Access Supervision - Supervision or consultation conclusions
- Take Responsible Action - Action taken and the rationale for the action
- Extend the action - All follow-up actions taken

If you don't write it, it is as if it did not happen!

4.22

Small-Group Exercise: Case Studies

- Form groups of three
- Read your assigned case study
- Complete the worksheet in Resource Page 4.7
- Use the information and examples in the other Resource Pages as aids

4.23

The Collaborative Assessment and Management of Suicide (CAMS) – Philosophy

- Empathy for Suicidal States
- Collaboration
- Honesty
- Focus on Suicide
- Outpatient Oriented
- Flexible and nondenominational

4.24

The Collaborative Assessment and Management of Suicide (CAMS) – Treatment Road Map

- Initial Session: complete the SSF-4 Initial Session Form
 - ▣ Assessment
 - ▣ Identifying Drivers
 - ▣ Treatment Plan
 - ▣ Crisis Stabilization Plan
- Tracking Interim Sessions (9-11 sessions)
- Outcome/deposition Final session

(Note: Suicidal Status Form (SSF) which is a multipurpose engagement, assessment, treatment-planning, tracking, and outcome/disposition clinical tool that serves as the indispensable roadmap for CAMS-guided care.)

Jobes, D. A. (2017). Managing Suicidal Risk, A Collaborative Approach, Second Edition. 47(3). doi:10.1007/s10879-017-9357-8

4.25

Break

15 minutes

4.26

[illegible]

Resource Page 4.1: Suicide Warning Signs Exercise

Instructions

For each case study, answer these questions:

1. Is there a direct warning sign (or more than one) in the description?
2. Is there an indirect warning sign (or more than one) in the description?
3. Do you think this person is at low, moderate, or high risk of committing suicide?

Case Studies

Client 1: Katrina is interviewed for admission to treatment for prescription medication abuse (tranquilizers and sleeping pills). During the interview, she reports that she was diagnosed with depression several years ago, but that she couldn't afford the medication prescribed for her. She says she thinks that her family might be better off if she weren't around. She describes her life as having no real purpose, except as a mother to her teenage children, but that they really don't need her anymore. Katrina says she has decided to enter treatment because "taking all the pills at once started to sound like a good idea" and that scared her. She also says she thinks about crashing the car sometimes when she is driving, but she doesn't want to hurt anyone else, and it also might be too painful.

Client 2: Richard comes to his third outpatient SUD treatment group session (for marijuana and cocaine use) and is unusually quiet. When asked why, he says he doesn't want to talk. When pressed a bit, he says his job is a dead end, he hates it, but with the economy being so bad, he knows he should keep the job, even though he feels trapped. He says he feels trapped at home, too. He doesn't love his wife and really never did; he only got married because she was pregnant. He says he's not sure "it" is worth the effort. When asked what he means by this, he says he is not sure getting treatment is worth the effort. He's not having any fun anymore. Richard stands up, obviously agitated, and it seems he might leave the room. Another member of the group says he hopes Richard sticks with it, because he is worth it. Richard sits back down and begins to cry. He says no one ever said he was worth it before.

Clients 3: Anil and Nadia (ages 60 and 56, respectively) have come to a joint counseling session. Anil is in treatment because he began using tranquilizers heavily a year ago, following the death of their son, who was 36 when he was killed in a car crash that may have been a completed suicide (the evidence is inconclusive). Anil also has been drinking heavily for the past 2 months, which greatly concerns Nadia. She will no longer be a passenger in a car if he is driving, and she also told their daughter-in-law not to let Anil drive the grandchildren anywhere. Anil and Nadia have recently been to a solicitor to make their wills, which they say was prompted by the realization after their son's death that it is important to have one's affairs in order. Anil says he is willing to quit drinking because he loves his family and doesn't want to hurt them. Nadia says she spends some

time every day thinking about dying, but she would never hurt herself because she knows how much it would hurt Aanil, their daughter-in-law, and the grandchildren. At nearly the end of the first session, Nadia asks the counselor whether it would be a good idea to get rid of the gun they have in the house.

Client 4: Kamal, age 19, is interviewed for SUD treatment (cocaine abuse, mostly). He says his doctor wants him to stop using anything, including alcohol, because his liver is in bad shape because of hepatitis. He has been using drugs since age 12. Kamal recently lost his job, and his parents will no longer let him live in their home because he has stolen valuable property and he behaves violently when he is using. His parents have never called the police. Kamal reports that he has often thought about killing himself and decided that if he was going to do it, he would probably hang himself because it would be something that he could do on his own, with no danger to anyone else. He says he also thinks about driving into a bridge abutment, but since he doesn't have a car, he'd have to steal one to do that. He says he used to enjoy drag racing in his best friend's car, but his friend isn't talking to him any longer because Kamal punched him one night when they were using together, about a year ago.

Resource Page 4.2: Step 1—Gather Information¹

There are two steps to gathering information:

- Screening for and identifying warning signs; and
- Asking followup questions.

Screening

Screening consists of asking very brief, uniform questions at intake (and throughout treatment as necessary) to determine whether further questions about suicide risk are necessary. There is a myth that asking a person about suicidal thoughts may put the idea in his or her head and increase the risk. This is not true. Being asked about suicide may actually be a relief for many people.

Sample Screening Questions

Introducing the topic (use either statement):

1. Now I am going to ask you a few questions about suicide.
2. I have a few questions to ask you about suicidal thoughts and behaviors.

Screening for suicidal thoughts (ask either question):

1. Have you thought about killing yourself?
2. Have you thought about carrying out suicide?

Screening for suicide attempts (ask either question):

1. Have you ever tried to take your own life?
2. Have you ever attempted suicide?

Asking Follow-up Questions

Ask follow-up questions when clients respond “yes” to one or more screening questions or any time you notice a warning sign. The purpose of asking follow-up questions is to have as much information as possible so that you, your supervisor, and the treatment team can develop a good plan of action. You also will want to provide as much information as possible to another provider should you make a referral.

¹ Center for Substance Abuse Treatment. Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2017. (Treatment Improvement Protocol (TIP) Series, No. 50.)

Sample Follow-up Questions About Suicidal Thoughts

1. Can you tell me about the suicidal thoughts?
2. If the client requires more direction:
 - What brings them on?
 - How strong are they?
 - How long do they last?
3. If you do not already know:
 - Have you made a **plan**? (If yes) What is your plan?
 - Do you have access to a **method** of suicide? A gun? Pills?
 - Do you **intend** to attempt suicide?

Sample Follow-up Questions About Past Suicide Attempts

1. Please tell me about the attempt.
2. If the client requires more direction:
 - What brought it on?
 - Where were you?
 - Were you drinking or high?
3. To gather information about **lethality**:
 - What method did you use to try to kill yourself?
 - Did you receive emergency medical treatment?
4. To gather information about **intent**:
 - Did you want to die? How much?
 - Afterward, were you relieved you survived, or did you feel you would rather have died?

Resource Page 4.3: Step 2—Access Supervision¹

You should not make a judgment about the seriousness of suicide risk or try to manage suicide risk on your own unless you have an advanced mental health degree and specialized training in suicide risk management and it is understood by your program that you are qualified to manage such risk independently.

Receiving input from a peer is not enough. Although such input may be helpful, consultation is a more formal process whereby information and advice are obtained from:

- A professional with clear supervisory responsibilities;
- A multidisciplinary team that includes such a person; or
- An outside consultant experienced in managing suicidal clients who has been approved by your program for this purpose.

When obtaining supervision or consultation, assemble all the information you have gathered on your client's suicidal thoughts and/or suicide attempts through the screening and follow-up questions, as well as data from other sources of information (e.g., other providers, family members, treatment records).

In some circumstances, you will need to obtain immediate consultation. In other circumstances, obtaining consultation at regularly scheduled supervision or team meetings may be sufficient.

Circumstances Requiring Immediate Supervision or Consultation

Circumstances **at intake** requiring access to immediate supervision or consultation include the following:

- Direct warning signs are evident (suicidal communication, seeking access to method, making preparations);
- Answers to follow-up questions to suicide screening questions suggest that there is current risk;
- Answers to follow-up questions to indirect warning signs suggest that there is current risk; and
- Additional information (e.g., from the referral source, family member, medical record) suggests that there is current risk.

Circumstances **during treatment** that require access to immediate supervision or consultation include:

- Emergence (or reemergence) of direct warning signs suggests current risk;
- Emergence (or reemergence) of indirect warning signs that, on followup questioning, suggests current risk;

¹ Center for Substance Abuse Treatment. Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2017. (Treatment Improvement Protocol (TIP) Series, No. 50.)

- Answers to suicide screening questions asked during the course of treatment suggest current risk; and
- Additional information (e.g., from another provider or family member) suggests current risk.

Circumstances That Can Wait for Regularly Scheduled Supervision or Consultation

Circumstances **at intake** requiring access to regularly scheduled supervision or consultation include the following:

- One or more indirect warning signs are present, but answers to follow-up questions indicate that there is no reason to suspect current risk for suicidal behavior (e.g., a client is socially isolated and abusing substances, but otherwise shows no indications of suicidal thoughts or plans);
- One or more risk factors are present, but there are no accompanying warning signs or other indications to suspect current risk for suicidal behavior;
- During screening, client discloses a history of suicidal thoughts or suicide attempts, but there are no accompanying warning signs or other indications to suspect current risk for suicidal behavior; and
- Additional information (e.g., from the referral source or a family member) suggests your client has a history of suicidal thoughts or attempts, but there are no accompanying warning signs or other indications to suspect current risk for suicidal behavior.

Circumstances **during treatment** that require access to regularly scheduled supervision or consultation include the following:

- Client reports (or alludes to) a history of suicidal thoughts that you had not previously been aware of, but there are no accompanying warning signs or other indications to suspect current risk for suicidal behavior;
- Client reports (or alludes to) prior suicide attempts that you had not previously been aware of, but there are no accompanying warning signs or other indications to suspect current risk for suicidal behavior;
- Additional information (e.g., from another provider or family member) suggests a history of suicidal thoughts or attempts that you had not previously been aware of, but there are no accompanying warning signs or other indications to suspect current risk for suicidal behavior; and
- Client with a history of suicidal thoughts or behaviors experiences an acute stressful life event or a setback in treatment (e.g., substance abuse relapse), but there are no accompanying warning signs or other indications to suspect current risk for suicidal behavior.

Resource Page 4.4: Step 3—Take Responsible Action¹

A useful guiding principle in taking responsible action is that your actions should make good sense given the seriousness of suicide risk. The key factor—although not the only factor—in considering the actions to take is a judgment about the seriousness of risk. Seriousness is defined as the likelihood that a suicide attempt will occur and the potential consequences of an attempt.

If a client is judged to be likely to carry out a suicide attempt (e.g., has persistent suicidal thoughts and a clear plan) and if the client expects the suicide attempt to be lethal (e.g., a plan to use a gun that the client keeps at home), the level of seriousness is high. In contrast, if a client is judged to be unlikely to carry out an attempt (e.g., has fleeting ideation, no clear plan, and no intention to act) and any attempt may be expected to be non-lethal (e.g., thoughts of swallowing some aspirin if there is any in the medicine cabinet), the level of seriousness is low. Judgments about the degree of seriousness of risk should be made in consultation with a supervisor and/or a treatment team, not by a counselor acting alone.

The actions taken should be sensible in light of the information that has been gathered about suicidal thoughts and/or previous suicide attempts. Although the potential actions are many, they can generally be described along a continuum of intensiveness. In instances of greater seriousness, you will generally take more intensive actions. For less serious circumstances, you will likely take less intensive actions. Note that “less intensive” does not mean no action; it merely indicates that the counselor may have more time to formulate a response, the actions may be of lower intensity, and/or fewer individuals and resources may be involved.

Counselors are also advised to be aware of local emergency services providers who are trained and experienced at providing medical intervention for suicide attempts. Such providers must be prepared to use pharmacological intervention (e.g., naloxone) for suicide attempts by overdose.

Possible Responsible Actions

- Arrange a referral:
 - To a clinician for further assessment of suicide risk;
 - To a provider for mental health counseling;
 - To a provider for medication management;
 - To an emergency services provider (e.g., hospital emergency department) for acute risk assessment;

¹ Center for Substance Abuse Treatment. Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2017. (Treatment Improvement Protocol (TIP) Series, No. 50.)

- To a mental health mobile crisis team that can provide outreach to a physically inaccessible client at his or her home (or shelter) and make a timely assessment; or
 - To a more intensive substance abuse treatment setting.
- Restrict access to methods of suicide (you will need the help of family members or friends).
 - Temporarily increase the frequency of care, including more frequent telephone check-ins.
 - Temporarily increase the level of care (e.g., refer client to residential or hospital-based treatment).
 - Involve a case manager if possible (e.g., to coordinate care, to check on the client occasionally).
 - Involve the primary mental disorder care provider if there is one.
 - Encourage the client to attend (or increase attendance at) 12-Step meetings such as Alcoholics Anonymous, Narcotics Anonymous, or Cocaine Anonymous.
 - Enlist family members or significant others (selectively, depending on their health, closeness to the client, and motivation) in observing indications of a return of suicide risk.
 - Observe the client for signs of a return of risk.
 - Create a safety card (see below) with the client in the event of a return of acute suicidal thoughts.
 - Create a detailed safety plan with the client in the event of relapse to alcohol or drugs.
 - Give the client an emergency hotline number.
 - Invite the client to contact you (or an emergency hotline) in the event of acute suicidal thoughts.

Safety Cards

With all clients with suicidal risk, consider developing with the client a written **safety card** that includes at a minimum:

- A 24-hour crisis number, if possible;
- The phone number and address of the nearest hospital emergency department;
- The counselor's contact information; and
- Contact information for additional supportive individuals whom the client may turn to when needed (e.g., sponsor, supportive family member).

To maximize the likelihood that the client will make use of the card, it should be personalized and created with the client (not merely handed to him or her). Discuss with the client the types of signs and situations that would warrant using one or more of the resources on the card. It is ideal to create a wallet-size card with this information, so clients can easily keep it with them. Have backup copies of the card available in the event that the client loses the card (which frequently happens) so that it can be quickly replaced. Check with the client from time to time to confirm that he or she still has the card (ask the client to show it to you) and remains willing to use it if the need arises.

Resource Page 4.5: Step 4—Extend the Action¹

A common misconception is that suicide risk is an acute problem that, once dealt with, ends. Unfortunately, individuals who are suicidal commonly experience a return of suicide risk following any number of setbacks, including relapse to substance use, a distressing life event (e.g., breakup with a partner), increased depression, or any number of other situations. Sometimes suicidal behavior even occurs in the context of substantial improvement in mood and energy. Therefore, monitoring for signs of a return of suicidal thoughts or behavior is essential.

There is also a tendency to refer a client experiencing suicidal thoughts and behaviors to another provider and then assume that the issue has been taken care of. This is a mistake. It is essential to follow up with the provider to determine that the client kept the appointment. It is also critical to coordinate care on an ongoing basis, for example, to alert a provider that a client has relapsed and may be vulnerable to suicidal thoughts. Extending the action emphasizes the importance of watching for a return of suicidal thoughts and behaviors, following up with referrals, and coordinating on an ongoing basis with providers who are addressing the client's suicidal thoughts and behaviors.

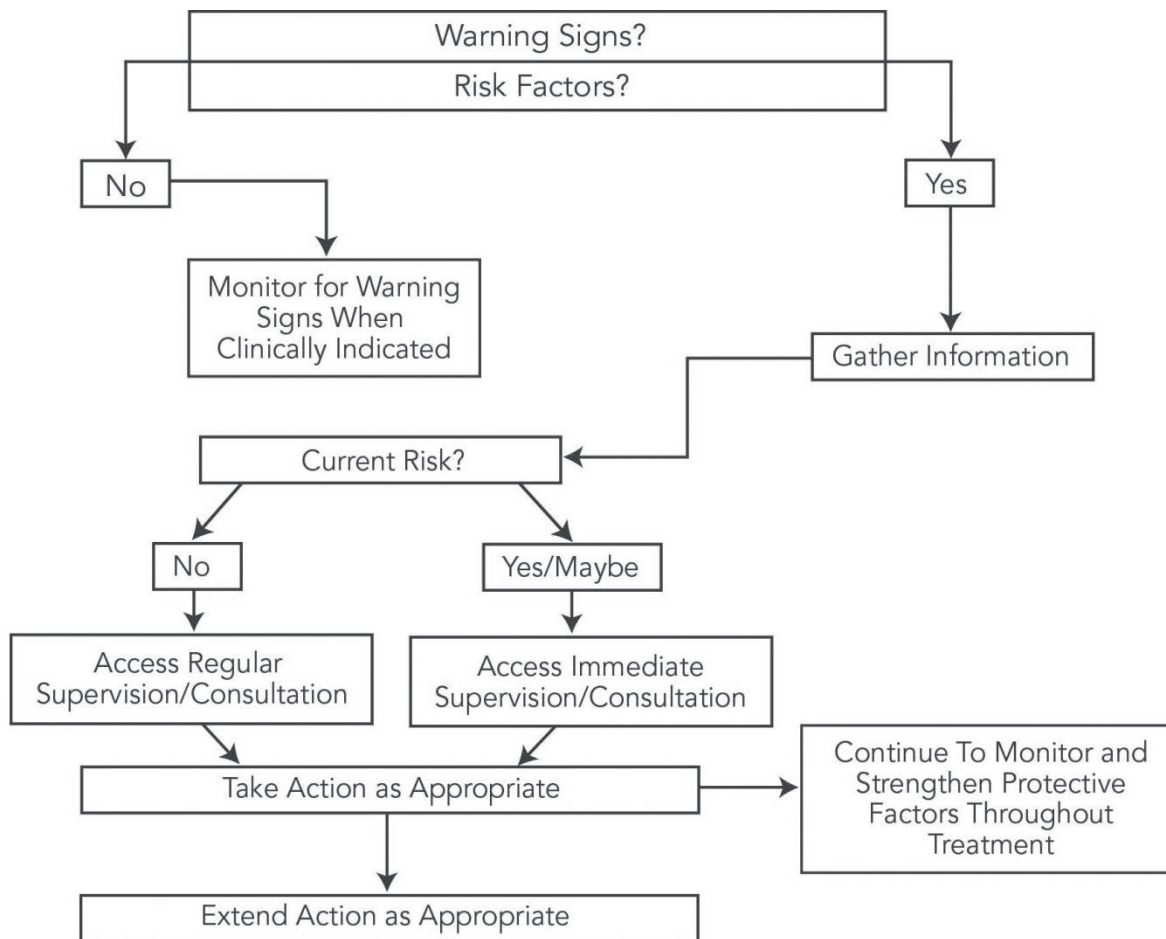
Examples of Extending the Action

- Confirm that a client has kept the referral appointment with a mental health provider (or other professional).
- Follow-up with the hospital emergency department when a client has been referred for acute assessment.
- Coordinate with a mental health provider (or other professional) on an on-going basis.
- Coordinate with a case manager on an on-going basis.
- Check with the client about any recurrence of or change in suicidal thoughts or attempts.
- Confirm that the client still has his or her safety card (ask the client to show it to you) and remains willing to use it if the need arises (see Resource Page 4.4 for information about safety cards).
- Check with family members (with the client's knowledge and consent) about any recurrence of or change in suicidal thoughts or attempts.
- Reach out to family members to keep them engaged in the treatment process after a suicide crisis passes.

¹ Center for Substance Abuse Treatment. Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2017. (Treatment Improvement Protocol (TIP) Series, No. 50.)

- Observe the client for signs of a return of risk.
- Confirm that the client and, where appropriate, the family still have an emergency phone number to call in the event of a return of suicidal thoughts.
- Confirm that the client still does not have access to a method of suicide (e.g., gun, stash of pills).
- Follow-up with the client about suicidal thoughts or behaviors if a relapse (or other stressful life event) occurs.
- Monitor and update the treatment plan as it concerns suicide.
- Document all relevant information about the client's condition and your responses, including referrals made and the outcomes of the referrals.
- Complete a formal treatment termination summary when and under whatever circumstances this stage of care is reached.

Resource Page 4.6: Decision Tree: Assessing and Addressing Suicide Risk¹



¹Center for Substance Abuse Treatment. Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2017. (Treatment Improvement Protocol (TIP) Series, No. 50.)

Resource Page 4.7: Four-Step Process Worksheet

Gather Information (see Resource Page 4.2)	Access Supervision (see Resource Page 4.3)
Take Responsible Action (see Resource Page 4.4)	Extend the Action (see Resource Page 4.5)

Pascal

SUD History

Pascal is a 61-year-old man who began using injection drugs as a young adult and contracted hepatitis C. He quit using injection drugs without treatment and about 10 or 15 years later developed alcohol dependence. He entered treatment 5 years ago and has been abstinent for 18 months. He has a cirrhotic liver and has developed type 2 diabetes. He attends at least four Alcoholics Anonymous (AA) meetings a week, participates in an on-going recovery group, and sees an SUD counselor individually on an as-needed basis. He lives alone and has two grown children with whom he has occasional contact. He is still working in a supervisory position at a local small manufacturing plant where he has worked for 30 years, but he is afraid he will not be able to work much longer because of his poor health.

Suicide-Related History

Pascal tried to kill himself when he was in his twenties by overdosing on heroin. He was taken to an emergency room and released about 12 hours later. He did not follow up on treatment recommendations. He began having suicidal thoughts again following his last relapse 18 months ago. While drinking, he decided he might shoot himself but did not actually make a suicide attempt. Since stopping drinking and returning to treatment, he has had occasional thoughts of killing himself, particularly when the pain from his liver disease becomes burdensome and when he feels that he has no future. Pascal maintains that he is not acutely suicidal now but says he might act if the pain becomes worse or if he is unable to take care of himself. The suicidal thoughts arise when he feels hopeless and when he becomes afraid that he might reach a point of being physically unable to take care of himself. He took out his gun and examined it last week, an action that concerned his AA sponsor enough to urge Pascal to call his SUD treatment counselor for an appointment.

Phoolwati

SUD History

Phoolwati is a 44-year-old woman with a history of chronic bipolar disorder and substance dependence. These illnesses have created numerous problems, including relationship conflicts with her family, unstable employment and housing, and poor adherence to healthcare treatment. She is currently in an inpatient psychiatric unit that specializes in the treatment of co-occurring disorders following a relapse to crack cocaine use. Phoolwati has a long history of cocaine dependence with relatively brief periods of abstinence. She was hospitalized for cocaine dependence twice in the past 4 years. Her drug use is intertwined with bipolar symptoms, so it is difficult for her to remain clean when hypomanic or depressive symptoms occur, and, at the same time, her drug use makes these symptoms worse. She has done well since being hospitalized and has cooperated with treatment.

The primary challenge now concerns discharge planning. Phoolwati believes that she requires minimal aftercare treatment and intends to move back in with her brother and sister-in-law and their two children.

Suicide-Related History

Phoolwati has made two suicide attempts, the first one as a teenager. Her more recent attempt, which precipitated her admission to the co-occurring disorders unit, was made while she was coming off cocaine. She had been deeply depressed for several weeks and overdosed on a variety of drugs that had been prescribed for her over the last few years. She was unconscious when discovered and taken to the emergency department. Once stabilized medically, she was admitted to the co-occurring disorders program. Although she denies any suicidal thoughts at this time, staff members remain concerned about her potential for suicidal behavior on initiation of cocaine use, a likelihood given her chronic SUD history. She shows poor insight into the severity of her mental disorder, drug use, and suicide potential.

Chin Ho

SUD History

Chin Ho is a 39-year-old accountant. He is in a conflicted, long-term relationship. He is nearing completion of an intensive outpatient treatment program. During his twenties he used a variety of psychoactive substances, but his drug of choice was marijuana, sometimes laced with PCP. In his thirties, he began to use cocaine whenever he could afford it and has done so for 6 years now. This is his first treatment effort, and he entered treatment as a result of a crisis in his relationship. Also, he has been missing work as a result of his substance use and the volatility of the relationship. He went to a counselor through work, and that counselor identified Chin Ho's SUD and referred him to an intensive outpatient program.

Suicide-Related History

At the end of group last night, Chin Ho made a reference to suicide: "I might be better off dead." Until then, no significant warning signs of suicidality had been noted with Chin Ho. The group, however, immediately picked up on his comment and began to question him about suicidal thoughts, which he denied. His counselor, Joyce, believed it was important to follow up with Chin Ho after group. Joyce also recognized the importance of addressing the group's anxiety and concern about Chin Ho. Long-term risk factors for Chin Ho include depression, a troubled partner relationship, work-related problems, and minority sexual orientation. In addition, he is at a treatment transition point that may create vulnerability. Protective factors include a generally solid work history and remaining abstinent through the treatment program thus far.

Module 4—Managing Suicide Risk, Summary

Introduction to suicide, suicidal thoughts, and suicidal behaviors

- Suicide is an acute, deliberate act of self-harm resulting in death with at least some intention to die.
- Every year, over 800,000 people die from suicide—a global mortality rate of 11.4 per 100,000 people. That is 1 death every 40 seconds. These figures do not include suicide attempts that are up to 20 times more frequent than completed suicide.¹
- Suicide is a leading cause of death among people who misuse alcohol and drugs. Substance misuse significantly increases the risk of suicide: Approximately 22 percent of deaths by suicide involved alcohol intoxication, with a blood-alcohol content at or above the legal limit (CDC, 2014b);²
- Opiates (including heroin and prescription painkillers) were present in 20 percent of suicide deaths, marijuana in 10.2 percent, cocaine in 4.6 percent, and amphetamines in 3.4 percent (CDC, 2014b).³
- Compared with the general population in the United States, individuals treated for alcohol abuse or dependence are at about 10 times greater risk of suicide, and people who inject drugs are at about 14 times greater risk.⁴
- The risk varies globally, but the association between SUDs and suicide remains significant.
- Among those populations known to be at increased risk of suicide are people who use drugs (PWUD)11–13. Evidence from epidemiological and clinical research indicates a 7- to 22-fold increase in suicide mortality among PWUD relative to that expected in the general population.⁵
- Clearly, counselors working with clients with SUDs need to be able to identify suicide threats
- There are many risk factors for suicidal thoughts and behaviors. These risk factors include:
 - Prior history of suicide attempts (this is the most potent risk factor, although it should be remembered that about half of all deaths by suicide are first-time attempts);
 - Family history of suicide;

1. World Health Organization. (2014) (n.d.). Suicide prevention (SUPRE): The problem. Retrieved March 22, 2017, from http://www.who.int/mental_health/prevention/suicide/suicideprevent/en/
2. AMHSA, 2008; HHS, 2012; Wilcox, Conner, & Caine, 2004; Pompili et al., 2010
3. Wilcox, Conner, & Caine, 2004; SAMHSA, 2017).
4. Wilcox, H. C., Conner, K. R., & Caine, E. D. (2004). Association of alcohol and drug use disorders and completed suicide: An empirical review of cohort studies. *Drug and Alcohol Dependence*, 76, S11–S19
5. Murphy L, Lyons S, O’Sullivan M and Lynn E. Risk factors for completed suicide among people who use drugs: A scoping review protocol [version 1; peer review: awaiting peer review] *HRB Open Research* 2020, 3:45 <https://doi.org/10.12688/hrbopenres.13098.1>

- Severe substance use (e.g., dependence on multiple substances, early onset of dependence);
- Co-occurring mental disorders, like:
 - Depression (including substance-induced depression)
 - Anxiety disorders (especially PTSD)
 - Severe mental illness (schizophrenia, bipolar disorder)
 - Personality disorders
 - Anorexia nervosa
- A history of childhood abuse (especially sexual abuse)
- Stressful life circumstances, such as:
 - Low level of education, job loss, and continuing unemployment
 - Divorce or separation
 - Legal difficulties
 - Major and sudden financial losses
 - Social isolation, low social support
 - Conflicted relationships
- Certain personality traits, like:
 - Proneness to negative affect (sadness, anxiety, anger)
- Aggression and/or impulsive traits
 - Firearm ownership or access to a gun or easy access to dangerous medications as with a nurse or physician.

Suicidal Ideations and Suicide Plans

- Four basic concepts involved in suicide:
 - Suicidal ideations;
 - Suicide plans;
 - Suicide behaviors; and
 - Suicide warning signs.
- Suicidal ideations are much more common than suicidal behavior. Suicidal ideations lie on a continuum of severity from fleeting and vague thoughts of death to those that are persistent and highly specific. Serious suicidal ideations are frequent and intense and perceived by the person as uncontrollable.

- Suicide plans signal more serious risk to carry out suicidal behavior than suicidal ideation alone. Suicide planning lies on a continuum from vague and unrealistic plans (“I’ll just throw myself off a bridge”) to those that are highly specific and feasible (planning where to buy a gun and researching how to use it most effectively).
- Serious suicide planning may also involve rehearsal or preparation for a suicide attempt, for example, testing that a ceiling beam will actually hold if the person plans to hang himself or herself.
- Suicide behaviours: suicide is an acute, deliberate act of self-harm resulting in death with at least some intention to die.
- A suicide attempt is a deliberate act of self-harm with at least some intention to die but that does not result in death. Attempts have two major elements:
 - The subjective level of intent to die (from the individual’s subjective perspective, how intensely did he or she want to die and to what extent did he or she expect to die?); and
 - The objective lethality of the act (from a medical perspective, how likely was it that the behavior would have led to death?).
- Although all suicide attempts are serious, those with high intent (the client clearly wanted to die and expected to die) and high lethality (the behavior could have easily led to death) are the most serious.

Suicide Warning Signs

- Direct warning signs include:
 - Suicidal communications: Oral threats to hurt or kill oneself or talk of wanting or planning to die;
 - Seeking access to a method: Looking for ways to kill oneself by seeking access to guns, pills, or other methods; and
 - Making preparations: Giving away possessions or saying goodbye directly or indirectly.
- There are also indirect signs that are much less obvious. As part of ongoing assessment, counselors should query clients about indirect signs, particularly if depression is suspected. Indirect signs include:
 - I = Ideation (Suicidal Ideation)
 - S = Substance Abuse
 - P = Purposelessness- Lack of a sense of purpose in life or a reason for living
 - A = Anxiety
 - T = Trapped - A sense of being trapped—perceiving that one is in a terrible situation from which there is no escape

- H = Feelings of **hopelessness**, that things are not going to get better

Mnemonic (IS PATH WARM)

- W= Social **withdrawal** and increasing social isolation, including sudden interruption of communication with the counselor and team;
- A = Feelings of anger;
- R = Recklessness— taking dangerous risks without safety precautions; and
- M = Mood changes.

Mnemonic (WARM)

- Each sign in and of itself may or may not mean something significant. For example, an adolescent with mood swings might just be experiencing normal adolescence.
- And substance abuse is the norm for many clients. Even so, indirect signs should not be ignored, particularly if a person is experiencing more than one of them. Clusters of indirect warning signs should always be followed up quickly.
- Since these signs are not obvious, counselors need to ask clients whether they are experiencing them.

4 Step Process for Intervention

- The four steps form the acronym GATE. The steps are:
 - **G**ather information;
 - **A**ccess supervision;
 - **T**ake responsible action; and
 - **E**xtend the action.
- Descriptions of these steps are found in Resource Pages 4.2–4.5. A decision tree based on this process is in Resource Page 4.6.

The Collaborative Assessment and Management of Suicide (CAMS) – Philosophy

- CAMS is one of the tool for screening and evaluating suicidal risk.
- The success of CAMS depends firmly on a philosophical orientation that proposes some significant departures from conventional clinical practices about how best to understand and clinically assess and treat a person with suicidal risk. Below are key features of CAMS approach to caring for suicidal patients.
 1. Empathy for Suicidal States - listen to the patient's suicidal story in an empathetic and nonjudgmental fashion

2. Collaboration – the most important factor for successful CAMS-guided clinical care and engage in a highly interactive assessment process and directly solicit patient input to their treatment plan. Patients are never interrupted or talked over when assessment is being conducted, they are sought to make inputs at every opportunity.
3. Honesty – Focus on direct and respectful honesty about the entire situation created when suicidal risk is present, rather than component of care.
4. Focus on Suicide – persistently work together to eliminate suicide as a coping option, and to eliminate the suicidal drivers that make “patients” life at risk, and assist in the development of purpose and meaning rather than focusing on irrelevant issues for these attempts, such as kids or the economy, unless important.
5. Outpatient Oriented – keep a suicidal patient out of the hospital through collaborative development of suicide-specific outpatient treatment plan that includes careful development of stabilization plan and a problem-focused treatment.
6. Flexible and nondenominational – CAMS is designed for flexibility and adaptation to a range of theoretical approaches and the spectrum of clinical treatments.

The Collaborative Assessment and Management of Suicide (CAMS) – Treatment Road Map¹

- Overall treatment Road Map consists of
 - Initial Session: complete the SSF-4 Initial Session Form
 - Assessment,
 - Identifying Drivers,
 - Treatment Plan,
 - Crisis Stabilization Plan
 - Tracking Interim Sessions (9-11 sessions) - patients will be clinically “tracked” until their suicidal risk is either eliminated through treatment or other outcomes occur (e.g., “referral” or “treatment dropout”)
 - Outcome/deposition Final session - As a clinical intervention, CAMS comes to a close when criteria for “resolution” are met or other outcomes arise.
- (CAMS utilize Suicidal Status Form (SSF) which is a multipurpose engagement, assessment, treatment-planning, tracking, and outcome/disposition clinical tool that serves as the indispensable roadmap for CAMS-guided care.)

1. Jobes, D. A. (2017). Managing Suicidal Risk, A Collaborative Approach, Second Edition. 47(3). doi:10.1007/s10879-017-9357-8

MODULE 5

AVOIDING PERSONAL CRISIS: COUNSELOR SAFETY AND SELF-CARE

Content and timeline	131
Training goals and learning objective	131
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Content and Timeline	
Activity	Time
Introduction to Module 5	5 minutes
Presentation: Counselor safety overview	15 minutes
Small-group exercise: Ideas for making counseling safer	40 minutes
Reflective exercise: Personal safety planning	20 minutes
Presentation: Counselor self-care— Avoiding stress and burnout	15 minutes
Reflective exercise: Counselor self-care	20 minutes
Partner exercise: Planning for change	40 minutes
<i>Lunch</i>	<i>60 minutes</i>

Module 5 Goals and Objectives

Training goals

- To provide information on how to avoid unsafe professional situations;
- To provide an opportunity for participants to create plans to increase safety in the counseling setting;
- To provide information on stress and professional burnout; and
- To provide an opportunity for participants to create personalized plans to increase self-care and avoid burnout.

Learning objectives

Participants who complete Module 5 will be able to:

- Describe how to make counseling settings safer;
- Describe how to avoid unsafe professional situations;
- Determine personal and professional stressors and supports; and
- Create a plan to increase self-care and avoid burnout.



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Crisis Intervention
for Addiction Professionals



MODULE 5—AVOIDING PERSONAL CRISIS: COUNSELOR SAFETY AND SELF-CARE



DAP
Drug Advisory Programme

Module 5 Learning Objectives

- Describe how to make counseling settings safer
- Describe how to avoid unsafe professional situations
- Determine personal and professional stressors and supports
- Create a plan to increase self-care and avoid burnout

5.2

Counselor safety issues

- Clients in SUD counseling can become angry or even hostile; in the United States:
 - ▣ 49% to 81% of counselors report verbal or other nonphysical threats
 - ▣ 12% to 40% report physical assault
 - ▣ Most physical assaults resulted in no or very minor injuries
 - ▣ 30% resulted in any injury, and 10% in moderate injury

Source: Kleespies, P. (Ed.). (2009). Behavioral health emergencies: An evidence-based resource for evaluating and managing risk of suicide, violence, and victimization (pp. 434–435). Washington, DC: American Psychological Association.

5.3

Guidelines to effective communication

- Listen carefully and patiently
- Be empathic and do not judge
- Do not take a client's anger or frustration personally
- Avoid overreacting; remain calm, rational, and professional

5.4

Guidelines to effective communication (continued)

- Be aware of body language, movement, and tone of voice
- Respect personal space for you and the client
- If you made a mistake, admit it
- Review and clarify what the client needs
- Define your role and limitations and what you can realistically do for the client

"Pressly, P. K., & Heesacker, M. (2001). The physical environment and counseling: A review of theory and research. Journal of "Counseling and Development, 79(2), 148 – 160

5.5

Guidelines to effective communication (continued)

- Clarify messages, ask questions, and reflect
- Let clients know you are trying to understand their feelings
- Let clients know you are there to help them
- Ignore “challenging” questions

5.6

Make your setting safer

- Remove objects that could be used as weapons
- Arrange seating so that you and the client have clear access to an exit
- Have a method of communicating with others if you need help
- If client is at high risk for violence, meet where you can be seen or heard by others
- Pay attention to “gut” feelings of threat or danger

5.7

Evaluate for risk of violence: *Past risk factors*

- Violent behavior
- Behavior problems, especially aggression, in childhood or adolescence
- Arrests
- Having been a victim of violence



Source: American Psychological Association. (2010 update). Strategies for reducing patient violence toward clinicians. Retrieved March 22, 2017, from <http://www.apapracticecentral.org/update/2010/01-27/patient-violence.pdf>

5.8

Evaluate for risk of violence: Past risk factors (continued)

- Personality disorders
- Serious mental illness
- Brain injury or cognitive disorders
- Unstable relationships

5.9

Evaluate for risk of violence: **Current risk factors**

- Angry or hostile behavior, extreme emotion
- Acute symptoms of mania, schizophrenia, psychosis, delirium (Disturbed attention and awareness that developed over a short period of time and tend to fluctuate, presence of cognitive impairment)
- Thoughts or threats of violence



Source: American Psychological Association. (2010 update). Strategies for reducing patient violence toward clinicians. Retrieved March 22, 2017, from <http://www.apapracticecentral.org/update/2010/01-27/patient-violence.pdf>

ICD-11 for Mortality and Morbidity Statistics : 6D70 Delirium. Retrieved from <https://icd.who.int/browse11/l-m/en#/http://id.who.int/icd/entity/897917531>

Meagher, D. J., MacLulich, A. M., & Laurila, J. V. (2008). Defining delirium for the International Classification of Diseases, 11th Revision. *J Psychosom Res*, 65(3), 207-214. doi:10.1016/j.jpsychores.2008.05.015

5.10

Evaluate for risk of violence: **Current risk factors (continued)**

- Poor therapeutic alliance, poor response to treatment
- Access to weapons
- Impulsivity

5.11

Evaluate for risk of violence: *Future risk factors*

- Poor compliance with treatment; discontinuing medication
- Lack of social supports
- Peers who support criminal/aggressive behavior
- Unrealistic plans
- Impending losses

Source: American Psychological Association. (2010 update). Strategies for reducing patient violence toward clinicians. Retrieved March 22, 2017, from <http://www.apapracticecentral.org/update/2010/01-27/patient-violence.pdf>

5.12

Small-Group Exercise: Increasing counselor safety

- In small groups, brainstorm a list of ways to make counseling safer:
 - ▣ Before a session
 - ▣ During a session
 - ▣ After a session
- Record your lists on 3 newsprints
- Identify a presenter
- You have 25 minutes

5.13

Reflective Exercise

- Create a plan to improve your own personal safety as a counselor. Consider:
 - ▣ How safe is the setup of your office?
 - ▣ Does your program have procedures for calling for help?
 - ▣ Does the program have procedures to prevent that weapons can be brought into the institution?
 - ▣ What steps could you realistically take to improve your safety?
- You have 15 minutes

5.14

Counselor self-care

- Counseling is rewarding but **difficult work**:
 - ▣ Clients often have serious issues and difficult behaviors, and counselors may experience many emotions
 - ▣ Listening to clients' problems and feelings may bring up difficult thoughts and feelings in the counselor's past or present life.

5.15

Counselor self-care (continued)

- The work environment itself can be a source of stress:
 - ▣ Expectations may be unreasonably high
 - ▣ Difficulties with supervisor and colleagues
 - ▣ May not be feeling adequately rewarded for hard work
 - ▣ Cramped working area
 - ▣ Excess workload – too many cases assigned to a counselor resulting in poor quality of treatment outcome.
 - ▣ Excessive and unnecessary documentations
 - ▣ Poor biosecurity procedures that leads to stressful working environment

5.16

Counselor self-care (continued)

- Work stress may come from the counselor:
 - ▣ Very high expectations of self
 - ▣ Inadequate boundaries around the work (working many hours a week, skipping lunch breaks, not taking earned vacation time)
 - ▣ Feeling inadequately trained and not competent enough to do the job

5.17

Counselor self-care (continued)

- Stress can also come from personal situations:
 - ▣ Personal or family illness
 - ▣ Child care responsibilities and a new baby
 - ▣ Interpersonal problems with spouse or partner
- Counselors can suffer from burnout – which is emotional and physical fatigue caused by stress

5.18

Compassion Fatigue

- Compassion Fatigue can result from working with victims of trauma and is experienced as a sense of overwhelm
- It often involves an intense state of tension or excessive preoccupation with the cognitive, physical, psychological and emotional pain and suffering of others
- The counselor will exhibit symptoms including diminished interest in previously enjoyed activities, heightened emotional reactivity (e.g. anger and anxiety), hypervigilance, muscle tension, difficulty sleeping, and augmented or inflated physical reflex.

5.19

Reflective Exercise: Individual self-care

- Review Resource Page 5.1: Elements of Self-Care for Counselors
- Answer the following questions in your journal:
 - ▣ What are your personal and professional stressors?
 - ▣ What are your personal and professional supports?
 - ▣ Which of the strategies do you use now to effectively manage your work stress?
 - ▣ In which categories could you do more?

5.20

Partner Exercise: Planning for change

- Use Resource Page 5.2: Planning for Change
- Take turns developing a personal plan and helping your partner with his or her plan
- You have 15 minutes each

5.21

Lunch

60 minutes

5.22

Resource Page 5.1: Elements of Self-Care for Counselors¹

Awareness

- Awareness involves having knowledge about what it means to be a mental health professional, including an understanding of the risks for and symptoms of burnout and professional impairment.
- There are a variety of methods for improving awareness among mental health practitioners including participation in Acceptance and Commitment Therapy course, mindfulness and meditation training and self-reflection, and creative writing.

Balance

- Balance refers to distributing one's attention to various aspects of life, ensuring not to neglect important facets, and to maintaining a sense of equilibrium in both personal and professional realms, whereas imbalance occurs when satisfaction in one domain leads to negative outcomes in other domains.
- In order to achieve balance in life, take leisure time, engage in a variety of professional activities in addition to client work. Other strategies include: cultivating non-work-related passions, interests, and relationships, having a holistic view of well-being, limiting scope of practice when coping with significant personal life events, maintaining good work and personal life boundaries, using time management skills, taking needed breaks, having flexible work hours and locations, setting realistic work goals, and turning to spirituality.

Flexibility

- The term flexibility refers to a number of dynamic processes, including practitioners' utilization of effective coping strategies and to their openness and ability to adapt to and grow from life stress.
- Practitioners need to find ways to internally manage and externally respond to the varying demands of their work.
- They can engage in professional development on a regular basis is recommended for therapist self-care.
- Other practices are setting and reappraising goals, engaging in expressive writing or journaling, and engaging in Acceptance and Commitment Therapy.

1. Posluns, K., & Gall, T. L. (2020). Dear Mental Health Practitioners, Take Care of Yourselves: a Literature Review on Self-Care. *Int J Adv Couns*, 42(1), 1-20. doi:10.1007/s10447-019-09382-w

Physical Health

- Due to the sedentary nature of work, practitioners can experience physical health concerns such as tiredness, neck and back pain, greater fatigue and frequent headaches. In turn, these health problems can have a negative impact on practitioners' therapeutic alliances with clients.

Sleep

- Stress significantly reduces the quantity and quality of sleep, with poor sleep in turn triggering greater stress the next day. Insufficient sleep is linked to exhaustion and low professional efficacy, higher levels of stress and burnout.
- Hence practitioners can engage in sleep hygiene techniques, maintain a regular sleep schedule and get ample sleep each night. Self-monitoring sleep habits is an effective method of improving sleep hygiene. Other effective hygiene techniques include maintaining a regular sleep schedule, making the sleep environment restful and avoiding going to bed hungry or thirsty.

Diet and Exercise

- Diet and exercise are critical components of self-care. Having a balanced diet (a wide variety of foods in the right proportions, and consuming the right amount of food and drink) and a healthy lifestyle is ranked as the fourth most important self-care practice.
- Additionally, practitioners are recommended to exercise regularly as well as attend to hydration on a daily basis.

Social Support

- Social support refers to the resources and interactions provided by others and/or the connection to others that help one cope with stressful circumstances...[that] can come from a variety of sources, including family, friends, co-workers, supervisors.
- Strong social support is related to lower levels of perceived stress.
- Practitioners rely on many sources of support, including peer support, individual and/or group supervision, involvement in professional associations, colleague assistance programs, and personal therapy.
- Practitioners can also seek professional support from clinical supervisors, mentors, advisors, professional colleagues/peers, and professors.
- In particular, clinical supervision can be a resource for increasing awareness of the risks and symptoms of negative outcomes experienced by mental health practitioners, while at the same time providing a safe space for such symptoms to be recognized.

Spirituality

- Spirituality is defined as a search for the sacred in one's life that encompasses aspects of connection with self, others, and the divine, as well as purpose and ultimate meaning. Experienced therapists describe how a sense of spiritual connection sustains their professional efforts and helps to dispel feelings of isolation and despair.
- As a spiritual practice, mindfulness is defined as a type of awareness that entails being fully conscious of present-moment experience and attending to thoughts, emotions, and sensations as they arise without judgment and with equanimity.
- The mindfulness training seems to have a beneficial effect on stress levels, while the results on burnout, self-compassion, and psychological well-being are varied.

Resource Page 5.2: Planning for Change

1. The category of self-care I most need to work on is:

2. I would like to make the following **specific** change:

3. My current level of readiness to make this change is:

1	2	3	4	5	6	7	8	9	10
Not Ready			Unsure				Ready		

4. First steps I am willing to take are:

- a. _____
- b. _____
- c. _____
- d. _____

5. Some things that could interfere with my plan are:

6. Ways I could overcome these barriers include:

Module 5—Avoiding Personal Crisis: Counselor Safety and Self-Care, Summary

Counselor Safety Issues

- Clients in substance use disorder counseling can become angry or even hostile. Various studies and surveys conducted between 1986 and 2004 in the United States indicate that:
 - Between 49 percent and 81 percent of counselors had been subject to verbal or other non-physical threats (harassment, stalking, and so on); and
 - Between 12 percent and 40 percent had been subject to actual physical assault.¹
- Most physical assaults resulted in no or very minor injuries. Only 30 percent resulted in any injury, and 10 percent resulted in moderate injury.¹ However, serious injury or death has happened.
- Based on study and survey results, it appears that young or inexperienced counselors who are men and work in a hospital or inpatient setting are somewhat more at risk for client violence.¹
- Rates of assault vary from culture to culture, but there is always some risk. However, there are things counselors can do to improve their safety.

Guidelines to effective communication

- Sometimes it is enough to simply listen well and communicate effectively with a client to defuse a situation before it becomes hostile. The following are basic counseling skills, but they bear repeating:
 - Listen carefully and patiently. Confused or frustrated clients need to feel they are being heard and respected. Remember that when tempers flare, the best response is simply to listen. Anger that is listened to will often defuse.
 - Be empathic. Try not to judge clients' feelings. Try to put yourself in their shoes.
 - Don't take a client's anger or frustration personally. Remember that the client is angry or frustrated with the situation, not with you. Do not add to the client's stress, and yours, by getting defensive. Remain objective at all times.
 - Avoid overreacting. Remain calm, rational, and professional. Remember that how you respond will directly affect the client.
 - Keep non-verbal cues non-threatening. Be aware of your body language, movement, and tone of voice. The more a person loses control, the less he or she listens to actual words. Much more attention is paid to non-verbal communication.²

1. Kleespies, P. (Ed.). (2009). Behavioral health emergencies: An evidence-based resource for evaluating and managing risk of suicide, violence, and victimization (pp. 434–435). Washington, DC: American Psychological Association.

2. "Pressly, P. K., & Heesacker, M. (2001). The physical environment and counseling: A review of theory and research. Journal of "Counseling and Development, 79(2), 148 – 160

- Respect personal space. Stand at least 48-60 inches (1.21 meters -1.5 meters) from a person who is becoming angry or hostile.¹ Encroachment on personal space tends to make a person feel more threatened and angry. Standing eye-to-eye or toe-to-toe with a person sends a challenging message. Standing away and at an angle off to the side is less likely to cause an individual to become more agitated.
 - If you made a mistake, admit it. An honest acknowledgment of an error can quickly calm an angry client.
 - Review and clarify. If you are still unsure about what the client wants, back track to where the problem began.
 - Define your role and what you can do for the client. Let the client know your limitations. If you cannot solve the problem, direct the client (right away) to a person who can.
 - Clarify messages. Ask questions if a client is confused or unable to state what the problem is. Reflect back to the client what you are hearing to be sure you understand. Help clients define the problem and decide what they need.
 - Let clients know you are trying to understand their feelings. Simply saying, “I see that this is upsetting you” can make the client feel you care.
 - Let clients know you are there to help them. Ask, “What can I do to help?” Clients need to know that you are concerned and want to see that their needs are met.
 - Ignore “challenging” questions. If a client challenges your position, training, or other aspect of your professional qualifications, redirect his or her attention to the issue at hand. Answering “challenging” questions often fuels a power struggle and escalates a client’s frustration.
- In addition to good communication, there are ways to make the setting itself safer. A counselor can:
- Identify and remove objects that could be used as weapons, such as small heavy items, scissors, and so on;
 - Arrange seating so that the counselor and the client have clear access to an exit;
 - Prearrange a method of communicating with others, such as a panic button or emergency code or signal, in case help is needed;
 - Meet clients who are at high risk of violence in places where they can be seen or heard by others;
 - Use a team approach; often that is enough to stop aggressiveness; and
 - Pay attention to “gut” feelings of threat or danger.
- At the first meeting with any client, a counselor should evaluate the risk factors for violence. You should also evaluate risk factors at any point when violent thoughts are reported or when other clinical or behavioral changes in the client concern you.

- Begin with past risk factors and history, such as:¹
 - Past violent behavior;
 - Behavior problems, especially aggression, in childhood or adolescence;
 - Arrests for violence;
 - Having been a victim of violence;
 - Personality disorder (borderline or antisocial);
 - Serious mental disorder;
 - Brain injury or cognitive disorder; and
 - Unstable relationships.
- Clearly, not everyone with a serious mental disorder or unstable relationships is at risk of being violent. One or two risk factors may not mean anything, but a cluster of factors can indicate the need for extra caution when working with the person.
- Risk assessment also includes noting any current risk factors for violence, such as:¹
 - Angry or hostile behavior, extreme emotion (including agitation and suspiciousness);
 - Acute symptoms of mania, schizophrenia, psychosis, or delirium (Delirium is characterized by disturbed attention (i.e., reduced ability to direct, focus, sustain, and shift attention) and awareness (i.e., reduced orientation to the environment) that develops over a short period of time and tends to fluctuate during the course of a day, accompanied by other cognitive impairment such as memory deficit, disorientation, or impairment in language, visuospatial ability, or perception.^{2,3} Disturbance of the sleep-wake cycle (reduced arousal of acute onset or total sleep loss with reversal of the sleep-wake cycle) may also be present;
 - The client's thoughts or threats of violence.
 - Poor therapeutic alliance and poor response to treatment;
 - Access to weapons; and
 - Impulsivity.
- You should also be aware of behavior or upcoming changes that could indicate future risk for violence. These include:¹
 - Poor compliance with treatment (such as discontinuing medication); Lack of social supports;
 - Peers who support criminal or aggressive behavior;

1. American Psychological Association. (2010 update). Strategies for reducing patient violence toward clinicians. Retrieved March 22, 2017, from <http://www.apapracticecentral.org/update/2010/01-27/patient-violence.pdf>

2. Meagher, D. J., MacLulich, A. M., & Laurila, J. V. (2008). Defining delirium for the International Classification of Diseases, 11th Revision. *J Psychosom Res*, 65(3), 207-214. doi:10.1016/j.jpsychores.2008.05.015

3. ICD-11 for Mortality and Morbidity Statistics : 6D70 Delirium. Retrieved from <https://icd.who.int/browse11/l-m/en#/http://id.who.int/icd/entity/897917531>

- Unrealistic plans can lead to frustration of the person when he/she doesn't get what he/she expected leading to aggression; and
- Impending losses (such as likely loss of home, job, friends, family member).

Counselor self-care—Avoiding stress and burnout

- Counseling is rewarding but difficult work:
 - Clients often have serious issues and difficult behaviors, and counselors may experience many emotions, both positive and negative, in the course of a day.
 - Listening to clients' problems and feelings may bring up difficult thoughts and feelings in the counselor's past or present life.
- There are no "perfect" jobs, so the work environment can be a source of stress as well:
 - Expectations may be unreasonably high
 - Difficulties with supervisor and colleagues
 - May not be feeling adequately rewarded for hard work Cramped working area
 - Excess workload – too many cases assigned to a counselor resulting in poor quality of treatment outcome
 - Excessive and unnecessary documentations
 - Poor biosecurity procedures that leads to stressful working environment
- Work stress also may originate with the counselor. He or she
 - May have very high expectations of himself or herself;
 - May not set adequate boundaries around the work, working many hours a week, skipping lunch breaks, and not taking earned vacation time; or
 - May not feel adequately trained and competent to do the job.
- Stress may also come from personal situations that affect work, such as a personal or family illness, child care responsibilities and a new baby, or interpersonal problems with a spouse or partner. Conversely, when the difficulties and stress of work begin to interfere with their personal and family lives, counselors can suffer from burnout, emotional and physical fatigue caused by work stress.
- It is important that counselors realize the demands made on them (and that they make on themselves) and find positive ways to maintain their well-being and cope with stress.

Compassion Fatigue

- Compassion Fatigue can result from working with victims of trauma and is experienced as a sense of overwhelm.
- It often involves an intense state of tension or excessive preoccupation with the cognitive, physical, psychological and emotional pain and suffering of others.
- The counselor will exhibit symptoms including diminished interest in previously enjoyed activities, heightened emotional reactivity (e.g. anger and anxiety), hypervigilance, muscle tension, difficulty sleeping, and augmented or inflated physical reflex.
- Counselors may also experience overall changes in their personal and professional lives, increased clinical errors, violation of professional boundaries, withdrawal from others, and diminished clientele respect.
- Hence, counselors need to find positive ways to maintain their well-being and cope with stress.
- Resource Page 5.1 has a list of elements of self-care for counselors.

MODULE 6

INTEGRATING LEARNING INTO PRACTICE

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Content and Timeline	
Activity	Time
Introduction to Module 6 and review exercise	10 minutes
Small-group exercise: Developing a practice integration plan	60 minutes
<i>Break</i>	<i>15 minutes</i>
Learning assessment competition	20 minutes
Overall training evaluations	15 minutes
Program completion ceremony and socializing	30+ minutes

Module 6 Goals and Objective

Training goals

- To encourage participants to think about resources, barriers, and strategies for change; and
- To provide an opportunity to develop a personal practice integration plan.

Learning objective

Participants who complete Module 6 will have developed a personal practice integration plan.

Resource Page 6.1: Practice Integration Plan

1. The most important thing I learned from this training, and don't want to forget, is:

2. Changes I will make in my practice based on what I have learned are:

3. Some things that could interfere with my plans are (e.g., anticipated barriers):

4. Ways I could overcome these barriers include:

5. The following people (include supervisors, potential mentors, and so on) and resources (further training, reading) could help me in the following ways:

<i>Person or Resource</i>	<i>Possible Ways To Help</i>

APPENDIX A—GLOSSARY

co-occurring disorder (COD)	Both a substance use disorder and a mental or medical disorder (or both).
crisis	"A perception or experience of an event or situation as an intolerable difficulty that exceeds the person's current resources and coping mechanisms."¹ A state of disorganization and confusion in which the client faces frustration and profound disruption in his or her life. An immediate situation or short-term period when many emotions are felt—extreme uncertainty, fear, loss, grief. An emotional state in response to disruption in the client's life, not the disruption itself.
crisis management	The process by which a counselor provides a person in crisis with immediate help to solve the problem the person is facing and to reestablish balance or stability in his or her life. Crisis management is immediate, short term, and time limited.
GATE	In English, an acronym standing for a four-step process of intervention: Gather information Access supervision Take responsible action Extend the action.
suicidal ideation	Thoughts of committing suicide. Suicidal ideations lie on a continuum of severity from fleeting and vague thoughts of death to those that are persistent and highly specific. Serious suicidal ideations are frequent, intense, and perceived by the person as uncontrollable.
suicide	An acute, deliberate act of self-harm resulting in death with at least some <i>intention</i> to die.

¹James, K. J., & Gilliland, B. E. (2001). *Crisis intervention strategies*. Pacific Grove, PA: Brook/Cole.

suicide attempt	A deliberate act of self-harm with at least some intention to die, but that does not result in death. Attempts have two major elements: ■ The subjective level of intent to die (from the individual's subjective perspective, how intensely did he or she want to die and to what extent did he or she expect to die?); and ■ The objective lethality of the act (from a medical perspective, how likely was it that the behavior would have led to death?).
suicide plan	A plan to commit suicide. A suicide plan signals more serious risk to carry out suicidal behavior than suicidal ideation alone. Suicide planning lies on a continuum from vague and unrealistic plans ("I'll just throw myself off a bridge") to those that are highly specific and feasible (planning where to buy a gun and researching how to use it most effectively). Serious suicide planning may also involve rehearsal or preparation for a suicide attempt, for example, testing that a ceiling beam will actually hold if the person plans to hang himself or herself.
transitional states	Those times in a client's life when much change is taking place: moving, getting married, and so on.

APPENDIX B—RESOURCES

Global Drug Use Statistics

United Nations Office on Drugs and Crime. (2020). World drug report 2020. New York: United Nations.

World Health Organization. (2010). Management of substance abuse: The global burden. Geneva: Author. Retrieved December 10, 2010, from

World Health Organization. (2011). Management of substance abuse: Facts and figures.

Geneva: Author. Retrieved December 10, 2010, from http://www.who.int/substance_abuse/facts/en/

Crisis Intervention and Suicide Risk Management

Center for Substance Abuse Treatment. (2009). Addressing suicidal thoughts and behaviors in substance abuse treatment. Treatment Improvement Protocol Series 50. HHS Publication No. (SMA) 09-4381. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Center for Substance Abuse Treatment. Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2017. (Treatment Improvement Protocol (TIP) Series, No. 50.)

International Association for Suicide Prevention <http://www.iasp.info/>

Suicide Assessment Five-step Evaluation and Triage (SAFE-T)

Suicide Prevention Resource Center <http://www.sprc.org/>

WHO. (2006). Preventing suicide: A resource for counsellors. Geneva: Author. http://whqlibdoc.who.int/publications/2006/9241594314_eng.pdf

Counselor Safety

American Psychological Association. (2010 update). Strategies for reducing patient violence toward clinicians.

Pope, K. (n.d.). Resources for therapists who are stalked, threatened, or attacked by patients. <http://kspope.com/stalking.php>

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